General Assembly

Amendment

January Session, 2025

LCO No. **8138**

Offered by:
SEN. LOONEY, 11th Dist.
SEN. DUFF, 25th Dist.
SEN. CABRERA, 17th Dist.

To: Subst. Senate Bill No. **10** File No. 419 Cal. No. 241

"AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective October 1, 2025*) (a) As used in this section:

(1) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes; and

(2) "Mental health and substance use disorder benefits" has the same meaning as provided in section 38a-477ee of the general statutes, as amended by this act.

(b) (1) Not later than March 1, 2026, and annually thereafter, each health carrier shall file a certification with the Insurance Commissioner for the immediately preceding calendar year, certifying that such health carrier completed a review of such health carrier's administrative

practices for compliance with the state and federal mental health and substance use disorder benefit reporting requirements pursuant to sections 38a-477ee, as amended by this act, 38a-488c, 38a-488d, 38a-514c, 38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this act, and 38a-544 of the general statutes, as amended by this act, and the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

(2) If such health carrier determines that such health carrier's administrative practices for the immediately preceding calendar year comply with the state and federal mental health and substance use disorder benefit reporting requirements identified in subdivision (1) of this subsection, such certification filed pursuant to subdivision (1) of this subsection shall state such finding.

(3) If such health carrier determines that such health carrier's administrative practices for the immediately preceding calendar year fail to comply with the state and federal mental health and substance use disorder benefit reporting requirements identified in subdivision (1) of this subsection, such certification filed pursuant to subdivision (1) of this subsection shall state such finding and identify (A) each administrative practice of such health carrier not in compliance with such state and federal mental health and substance use disorder benefit reporting requirements, and (B) action that such health carrier will take to bring such health carrier's administrative practices into compliance with such state and federal mental health and substance use disorder benefit reporting requirements.

Sec. 2. Subsection (c) of section 38a-477ee of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(c) **[**(1)**]** Not later than April 15, 2021, and annually thereafter, the Insurance Commissioner shall submit each report that the commissioner received pursuant to subsection (b) of this section for the

calendar year immediately preceding to:

[(A)**]** (1) The joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with section 11-4a; and

[(B)**]** (2) The Attorney General, Healthcare Advocate and Commissioner of Health Strategy.

[(2) Notwithstanding subdivision (1) of this subsection, the commissioner shall not submit the name or identity of any health carrier or entity that has contracted with such health carrier, and such name or identity shall be given confidential treatment and not be made public by the commissioner.**]**

Sec. 3. (NEW) (*Effective October 1, 2025*) (a) (1) The commissioner, after providing an opportunity for a hearing in accordance with chapter 54 of the general statutes, may impose a civil penalty on any health carrier of not more than one hundred dollars with respect to each participant or beneficiary covered under a health insurance policy of such health carrier, provided such penalty shall not exceed an aggregate amount of one million dollars annually, for such health carrier's failure to comply with (A) the certification requirements pursuant to the provisions of section 1 of this act, (B) the state and federal mental health and substance use disorder benefit reporting requirements identified in subdivision (1) of subsection (b) of section 1 of this act, or (C) any other requirement pursuant to sections 38a-477ee, as amended by this act, 38a-488c, 38a-488d, 38a-514c, 38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this act, and 38a-544 of the general statutes, as amended by this act, and the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

(2) The commissioner may order the payment of such reasonable expenses as may be necessary to compensate the commissioner in conjunction with any proceedings under this section, which shall be

dedicated to the enforcement and implementation of the state and federal mental health parity laws and regulations adopted thereunder.

(b) (1) If any health carrier fails to file any data, report, certification or other information required by the provisions of section 38a-477ee of the general statutes, as amended by this act, or section 1 of this act, the commissioner shall impose a late fee on such health carrier of one hundred dollars per day from the due date of such filing of data, report, certification or information to the date such health carrier submits such filing to the commissioner.

(2) For any health carrier that files any incomplete data, report, certification or other information required by the provisions of section 38a-477ee of the general statutes, as amended by this act, and section 1 of this act, the commissioner shall provide notice to such health carrier of such incomplete filing that includes (A) a description of such data, report, certification or other information that is incomplete and any additional data that is needed to consider such filing complete, and (B) the date by which such health carrier is required to provide such data. The commissioner shall impose a late fee on such health carrier of one hundred dollars per day, commencing from the date identified by the commissioner pursuant to subparagraph (B) of this subdivision.

(c) The commissioner may waive any civil penalty imposed pursuant to subsection (a) of this section if the commissioner determines that the violation was due to reasonable cause and was not due to wilful neglect, or if such violation is corrected not more than thirty days after the date that the health carrier filed a certification of noncompliance with the commissioner pursuant to section 1 of this act.

(d) All civil penalties and late fees received by the commissioner pursuant to this section shall be deposited in the General Fund.

(e) The commissioner may engage the services of any health policy research organization or any other independent expert as the commissioner deems necessary to assist the commissioner in the review

of any violation of the nonquantitative treatment limitations requirements pursuant to section 38a-477ee of the general statutes, as amended by this act, and the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

Sec. 4. Section 38a-510 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing an individual health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy (A) for any prescribed drug for longer than thirty days, (B) for a prescribed drug for **[**cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer provided**]** the treatment of a disability, as defined in 42 USC 12102, as amended from time to time, provided such disability is expected to last for a continuous period of not less than five years, as determined by the insured's health care provider, and such prescribed drug is in compliance with approved federal Food and Drug Administration indications, or (C) for **[**the period commencing January 1, 2024, and ending January 1, 2027, inclusive, for the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"**]** a prescribed drug for the treatment of a mental or behavioral health condition,

provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications.

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) or (C) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

(b) (1) Notwithstanding the **[**sixty-day**]** thirty-day period set forth in subparagraph (A) of subdivision (2) of subsection (a) of this section, each insurance company, hospital service corporation, medical service corporation, health care center or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers and an override request shall be expeditiously granted when an insured's treating health care provider demonstrates that the drug regimen required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or

physical harm to the insured, or (D) is not in the best interest of the insured, based on medical necessity.

(2) Upon the granting of an override request, the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract.

(c) Nothing in this section shall (1) preclude an insured or an insured's treating health care provider from requesting a review under sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of section 38a-492i.

Sec. 5. Section 38a-544 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing a group health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy (A) for any prescribed drug for longer than thirty days, (B) for a prescribed drug for **[**cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer provided**]** the treatment of a disability, as defined in 42 USC 12102, as amended from time to time, provided such disability is expected to last for a continuous period of not less than five years, as determined by the insured's health care provider, and such prescribed drug is in compliance with approved federal Food and Drug

Administration indications, or (C) for **[**the period commencing January 1, 2024, and ending January 1, 2027, inclusive, for the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"**]** a prescribed drug for the treatment of a mental or behavioral health condition, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications.

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) or (C) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

(b) (1) Notwithstanding the **[**sixty-day**]** thirty-day period set forth in subparagraph (A) of subdivision (2) of subsection (a) of this section, each insurance company, hospital service corporation, medical service corporation, health care center or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers and an override request shall be expeditiously granted

when an insured's treating health care provider demonstrates that the drug regimen required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the insured, based on medical necessity.

(2) Upon the granting of an override request, the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract.

(c) Nothing in this section shall (1) preclude an insured or an insured's treating health care provider from requesting a review under sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of section 38a-518i.

Sec. 6. Subsection (b) of section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(b) No rate filed under the provisions of subsection (a) of this section shall be effective until it has been approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474. <u>If the commissioner determines that a health carrier's average premium rate increase, as approved by the commissioner, exceeded the health care</u>

cost growth benchmark established pursuant to section 19a-754g for each of the two most recent plan years for which such health care cost growth benchmark data is available, the commissioner may reduce such health carrier's requested rate filed under the provisions of subsection (a) of this section by not more than two percentage points of such premium rate filed in addition to any other rate reductions authorized under this title.

Sec. 7. Subsection (a) of section 38a-513 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) (1) No group health insurance policy, as defined by the commissioner, or certificate shall be delivered or issued for delivery in this state unless a copy of the form for such policy or certificate has been submitted to and approved by the commissioner under the regulations adopted pursuant to this section. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for reviewing such policies and certificates. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such order.

(2) No group health insurance policy or certificate for a small employer, as defined in section 38a-564, shall be delivered or issued for delivery in this state unless the premium rates have been submitted to and approved by the commissioner. If the commissioner determines that any small group health insurance carrier's average premium rate increase, as approved by the commissioner, or certificate for a small

employer, exceeded the health care cost growth benchmark established pursuant to section 19a-754g for each of the two most recent plan years for which such health care cost growth benchmark data is available, the commissioner may reduce such policy's or certificate's requested premium rate filing under the provisions of subsection (a) of this section by not more than two percentage points of such premium rate filed in addition to any other premium rate reductions authorized under this title. Premium rate filings shall include the information and data required under section 38a-479qqq if the policy is subject to said section, and an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the policy. Each premium rate filed on or after January 1, 2021, shall, if the insurer intends to account for rebates, as defined in section 38a-479ooo in the manner specified in section 38a-479rrr, account for such rebates in such manner, if the policy is subject to section 38a-479rrr. As used in this subdivision, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

Sec. 8. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "General anesthesia" has the same meaning as provided in section 20-123a of the general statutes; and

(2) "Medical necessity" has the same meaning as provided in section 38a-482a of the general statutes.

(b) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, that provides coverage for any medically necessary surgical procedure, shall impose unilateral arbitrary limitations on reimbursement for medically necessary ancillary services, including, but not limited to, (1) any arbitrary time limit on reimbursement for general anesthesia provided during any such medically necessary surgical procedure, or (2) any

denial, reduction, termination or failure to provide such reimbursement, in whole or in part, for general anesthesia solely because the duration of care exceeded a predetermined time limit as determined by the insurer.

Sec. 9. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "General anesthesia" has the same meaning as provided in section 20-123a of the general statutes; and

(2) "Medical necessity" has the same meaning as provided in section 38a-482a of the general statutes.

(b) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, that provides coverage for any medically necessary surgical procedure, shall impose unilateral arbitrary limitations on reimbursement for medically necessary ancillary services, including, but not limited to, (1) any arbitrary time limit on reimbursement for general anesthesia provided during any such medically necessary surgical procedure, or (2) any denial, reduction, termination or failure to provide such reimbursement, in whole or in part, for general anesthesia solely because the duration of care exceeded a predetermined time limit as determined by the insurer.

Sec. 10. (NEW) (*Effective July 1, 2026*) (a) As used in this section:

(1) "Facility fee" has the same meaning as provided in section 19a-508c of the general statutes; and

(2) "Self-pay patient" has the same meaning as provided in section 17b-341 of the general statutes.

(b) (1) Each insurer, health care center, hospital service corporation, medical service corporation, preferred provider network or other entity that enters into, renews or amends a contract with a health care provider on or after July 1, 2026, to provide covered benefits to insureds or

enrollees in this state shall include in such contract a provision requiring such insurer, health care center, hospital service corporation, medical service corporation, preferred provider network or other entity to reimburse the contracting health care provider for a covered outpatient benefit that uses a current procedural terminology evaluation and management (CPT E/M) code, current procedural terminology assessment and management (CPT A/M) code or drug infusion code in an amount equal to one hundred fifty per cent of the nonfacility rate in the current Medicare physician fee schedule established by the federal Centers for Medicare and Medicaid Services.

(2) No health care provider shall directly or indirectly charge, bill or otherwise solicit payment for any such outpatient benefit described in subdivision (1) of this subsection that exceeds one hundred fifty per cent of the nonfacility rate in the current Medicare physician fee schedule established by the federal Centers for Medicare and Medicaid Services. The provisions of this subdivision shall apply to any individual or entity that provides reimbursement for any such outpatient benefit, including, but not limited to, self-pay patients and health benefit plans that do not have an existing contract with such health care provider. No health care provider shall directly or indirectly charge, bill or otherwise solicit payment for a facility fee for any such outpatient benefit.

(c) The Insurance Commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2025*	New section
Sec. 2	*October 1, 2025*	38a-477ee(c)
Sec. 3	*October 1, 2025*	New section
Sec. 4	*January 1, 2026*	38a-510
Sec. 5	*January 1, 2026*	38a-544
Sec. 6	*January 1, 2026*	38a-481(b)
Sec. 7	*January 1, 2026*	38a-513(a)

Sec. 8	*January 1, 2026*	New section
Sec. 9	*January 1, 2026*	New section
Sec. 10	*July 1, 2026*	New section