



Senate

General Assembly

File No. 209

February Session, 2026

Senate Bill No. 341

Senate, March 26, 2026

The Committee on Insurance and Real Estate reported through SEN. CABRERA of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (c) of section 38a-479b of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective January*
3 *1, 2027*):

4 (c) (1) No contracting health organization shall cancel, deny or
5 demand the return of full or partial payment for an authorized covered
6 service due to administrative or eligibility error, more than [eighteen]
7 twelve months after the date of the receipt of a clean claim, except if:

8 (A) Such organization has a documented basis to believe that such
9 claim was submitted fraudulently by such provider;

10 (B) The provider did not bill appropriately for such claim based on
11 the documentation or evidence of what medical service was actually
12 provided;

13 (C) Such organization has paid the provider for such claim more than
14 once;

15 (D) Such organization paid a claim that should have been or was paid
16 by a federal or state program; or

17 (E) The provider received payment for such claim from a different
18 insurer, payor or administrator through coordination of benefits or
19 subrogation, or due to coverage under an automobile insurance or
20 workers' compensation policy. Such provider shall have one year after
21 the date of the cancellation, denial or return of full or partial payment to
22 resubmit an adjusted secondary payor claim with such organization on
23 a secondary payor basis, regardless of such organization's timely filing
24 requirements.

25 (2) (A) Such organization shall give at least thirty days' advance
26 notice to a provider by certified mail, return receipt requested, electronic
27 mail to such electronic mail address designated by such provider or
28 facsimile of the organization's cancellation, denial or demand for the
29 return of full or partial payment pursuant to subdivision (1) of this
30 subsection.

31 (B) If such organization demands the return of full or partial payment
32 from a provider, the notice required under subparagraph (A) of this
33 subdivision shall disclose to the provider (i) the amount that is
34 demanded to be returned, (ii) the claim that is the subject of such
35 demand, and (iii) the basis on which such return is being demanded.

36 (C) Not later than thirty days after the receipt of the notice required
37 under subparagraph (A) of this subdivision, a provider may appeal such
38 cancellation, denial or demand in accordance with the procedures
39 provided by such organization. If any such organization fails to notify
40 the provider of such organization's determination on such appeal not
41 later than fifteen business days after receipt of such appeal from such
42 provider, such appeal shall be construed in favor of such provider. Any
43 demand for the return of full or partial payment shall be stayed during
44 the pendency of such appeal.

45 (D) If there is no appeal or an appeal is denied, such provider may
 46 resubmit an adjusted claim, if applicable, to such organization, not later
 47 than thirty days after the receipt of the notice required under
 48 subparagraph (A) of this subdivision or the denial of the appeal,
 49 whichever is applicable, except that if a return of payment was
 50 demanded pursuant to subparagraph (C) of subdivision (1) of this
 51 subsection, such claim shall not be resubmitted.

52 (E) A provider shall have one year after the date of the written notice
 53 set forth in subparagraph (A) of this subdivision to identify any other
 54 appropriate insurance coverage applicable on the date of service and to
 55 file a claim with such insurer, health care center or other issuing entity,
 56 regardless of such insurer's, health care center's or other issuing entity's
 57 timely filing requirements.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2027	38a-479b(c)

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note**State Impact:** None**Municipal Impact:** None**Explanation**

The bill shortens the period in which a health carrier can demand return of payment from a health care provider due to error and results in no fiscal impact to the state.

OLR Bill Analysis**SB 341*****AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS.*****SUMMARY**

This bill makes various changes to laws on claim payments and appeals between contracting health organizations (managed care organizations and preferred provider networks) and health care providers (for example, physicians).

Specifically, the bill:

1. reduces, from 18 months to 12 months, the time period after receiving a clean (complete and error-free) claim by which a contracting health organization may generally cancel, deny, or demand full or partial return of payment from a health care provider for an administrative or eligibility error;
2. specifies that for the existing requirement to give providers 30 days minimum advance notice of a payment cancellation, denial, or demand, notice must be sent (a) by certified mail, return receipt requested, if sent by mail or (b) to an email address the provider designates, if sent by email; and
3. requires the organization to notify the provider of its appeal determination within 15 business days after receiving the provider's appeal, or else the appeal must be construed in the provider's favor.

EFFECTIVE DATE: January 1, 2027

PAYMENT CANCELLATION, DENIAL, OR RETURN***Time Limit***

Current law generally prohibits a contracting health organization from canceling, denying, or demanding the return of full or partial payment for an authorized covered service due to administrative or eligibility error, more than 18 months after receiving the claim. The bill reduces this to 12 months after receiving the clean claim.

Under existing law, unchanged by the bill, the time limit does not apply if the:

1. organization (a) has a documented basis to believe that the provider fraudulently submitted the claim, (b) already paid the provider for the claim, or (c) paid a claim that should have been or was paid by a federal or state program; or
2. provider (a) did not bill the claim appropriately based on documentation or evidence of what medical service was provided or (b) received payment from a different insurer, payor, or administrator through coordination of benefits, subrogation, or coverage under an automobile insurance or workers' compensation policy.

Advance Notice

Under existing law, an organization must give a provider at least 30 days' advance notice of a payment cancellation, denial, or return demand by mail, e-mail, or fax. The bill specifies that if the notice is sent by mail, it must be sent by certified mail, return receipt requested; and if it is sent by email, it must be sent to the provider's designated email.

Appeal

By law, a provider may appeal, following the organization's procedures, a payment cancellation, denial, or return demand within 30 days after receiving notice of it. The bill requires the organization to notify the provider of the appeal determination within 15 days after receiving the appeal. Under the bill, if the organization fails to do so,

then the appeal must be construed in the provider’s favor.

Existing law, unchanged by the bill, requires a payment return demand to be stayed (postponed) during the appeal.

BACKGROUND

Related Bill

sHB 5377, favorably reported by the Insurance and Real Estate Committee, has similar provisions. It (1) reduces the period to cancel, deny, or demand payment on a clean claim from 18 months to 15 months; (2) has an identical provision on the mail and email requirements; and (3) requires the organization to communicate its appeal determination to the provider within 12 days of receiving the appeal.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 13 Nay 0 (03/12/2026)