Senate

General Assembly

File No. 223

February Session, 2026

Senate Bill No. 342

Senate, March 30, 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 HEALTH COVERAGE.

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

Section 1. (NEW) (*Effective July 1, 2026*) (a) 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:

(1) A provision requiring such insurer, health care center, hospital service corporation, medical service corporation, preferred provider network or other entity to:

(A) 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, telehealth codes or drug infusion code in an amount that does not vary based on

the facility where the contracting health care provider provides such benefit; and

(B) Use equal reimbursement rates for all contracting health care providers in the same geographic region, as determined by the Insurance Commissioner, and regardless of the employer or affiliation of any contracting health care provider, for each covered outpatient benefit described in subparagraph (A) of this subdivision if the reimbursement for such covered outpatient benefit is made on a fee-for-benefit basis or on the basis of bundled benefits per diagnosis, condition, procedure or another standardized bundle of health care benefits; and

(2) A conspicuous statement that such contract complies with the provisions of subdivision (1) of this subsection.

(b) 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.

Sec. 2. Subdivision (2) of subsection (a) of section 38a-477i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

(2) "Anti-steering clause" means any provision<u>, including, but not limited to, utilization management provisions,</u> in a health care contract that restricts the ability of the health carrier or health plan administrator from encouraging an enrollee to obtain a health care service from a competitor of a hospital or health system, including offering incentives to encourage enrollees to utilize specific health care providers such as centers of excellence or any other pay-for-performance program;

Sec. 3. (*Effective from passage*) The Insurance Commissioner shall conduct a study concerning various revisions to the insurance statutes, including, but not limited to, statutes concerning (1) excess insurance, (2) the Health Care Cabinet, and (3) outpatient health care services, including, injections and infusions, provided at a hospital-based facility located off-site from a hospital campus. Not later than January 1, 2027,

the commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance on the results and recommendations of such study.

Sec. 4. (NEW) (*Effective October 1, 2026*) (a) For purposes of this section, "clinical peer" has the same meaning as provided in section 38a-591a of the general statutes, "health carrier" has the same meaning as provided in section 38a-1080 of the general statutes and "downcode" means any adjustment of a health benefit claim by any insurer, health care center, hospital service corporation, medical service corporation, preferred provider network or other entity to a less complex or lower cost billing code in order to provide a lower reimbursement to a health care provider for such health benefit claim than is required for the actual service performed pursuant to such contract between such health care provider and such entity.

(b) No health carrier shall use a software tool, including, but not limited to, artificial intelligence or an algorithm, to automatically downcode or deny a health insurance claim submitted by a health care provider without review by a clinical peer.

Sec. 5. Subparagraph (C) of subdivision (1) of subsection (g) of section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

(C) For each contract entered into, renewed, amended or continued on or after July 1, 2023, between a health carrier and a participating provider that is a hospital, as defined in section 38a-493, or a parent corporation of a hospital or an intermediary of a hospital, if the contract is not renewed or is terminated by either the health carrier or the participating provider, the health carrier and the participating provider shall continue to abide by the terms of such contract, including reimbursement terms for all health care services and provisions provided under such contract, **[**for a period of sixty days from the date of termination or, in the case of a nonrenewal, from the end of the contract period. Except as otherwise agreed between such health carrier

and such participating provider, the reimbursement terms of any contract entered into by such health carrier and such participating provider during said sixty-day period shall be retroactive to the date of termination or, in the case of a nonrenewal, the end date of the contract period. This subparagraph shall not apply if the health carrier and participating provider agree, in writing, to the termination or nonrenewal of the contract and the health carrier and participating provider provide the notices required under subparagraphs (A) and (B) of this subdivision**]** until the earlier of the date the dispute is resolved or the policyholder's renewal date.

Sec. 6. Subdivision (2) of subsection (a) of section 38a-591c of the general statutes is amended by adding subparagraph (D) as follows (*Effective January 1, 2027*):

(NEW) (D) For each utilization review of a health care service ordered by a provider in the highest tier or level of the health carrier's tiered network, there shall be a rebuttable presumption that such health care service under review is medically necessary if such service was ordered by a provider in the highest tier or level of a health carrier's tiered network acting within such provider's scope of practice. A health carrier, or any utilization review company or designee of a health carrier that performs utilization review on behalf of the health carrier, shall have the burden of proving that a health care service ordered by a provider in the highest tier or level of such health carrier's tiered network is not medically necessary. For purposes of this subparagraph, "tiered network" has the same meaning as provided in section 38a-472f, as amended by this act.

Sec. 7. Subsection (c) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of the clinical peer or peers involved in making the review decision.

(B) If the adverse determination involves utilization review, the health carrier shall designate an appropriate clinical peer or peers to review such adverse determination. Such clinical peer or peers shall not have been involved in the initial adverse determination.

(C) (i) For each review of an adverse determination under this section for a health care service ordered by a provider in the highest tier or level of the health carrier's tiered network, there shall be a rebuttable presumption that each health care service under review is medically necessary if such service was ordered by a provider in the highest tier or level of such health carrier's tiered network acting within such provider's scope of practice. The health carrier may rebut such presumption by reasonably substantiating to the clinical peer or peers conducting the review under this section that such service is not medically necessary. For purposes of this clause, "tiered network" has the same meaning as provided in section 38a-472f, as amended by this act.

[(C)**]** (ii) The clinical peer or peers conducting a review under this section shall take into consideration all comments, documents, records and other information relevant to the covered person's benefit request that is the subject of the adverse determination under review, that are submitted by the covered person or the covered person's authorized representative, regardless of whether such information was submitted or considered in making the initial adverse determination.

(D) Prior to issuing a decision, the health carrier shall provide free of charge, by facsimile, electronic means or any other expeditious method available, to the covered person or the covered person's authorized representative, as applicable, any new or additional documents, communications, information and evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such documents, communications, information, evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized

representative, as applicable, a reasonable opportunity to respond prior to such date.

(2) If the review under subdivision (1) of this subsection is an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the covered person's authorized representative, as applicable, by telephone, facsimile, electronic means or any other expeditious method available.

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of a concurrent review request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

Sec. 8. Subsection (a) of section 38a-510 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 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, multiple sclerosis or rheumatoid arthritis, provided

such prescribed drug is in compliance with approved federal Food and Drug Administration indications**]** or for the treatment of disabling or life-threatening chronic diseases, or (C) 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".

(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.

Sec. 9. Subsection (a) of section 38a-544 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 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, multiple sclerosis or rheumatoid arthritis, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications**]** or for the treatment of disabling or life-threatening chronic diseases, or (C) 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".

(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.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2026*	New section
Sec. 2	*October 1, 2026*	38a-477i(a)(2)
Sec. 3	*from passage*	New section
Sec. 4	*October 1, 2026*	New section

Sec. 5	*October 1, 2026*	38a-472f(g)(1)(C)
Sec. 6	*January 1, 2027*	38a-591c(a)(2)(D)
Sec. 7	*January 1, 2027*	38a-591e(c)
Sec. 8	*October 1, 2026*	38a-510(a)
Sec. 9	*October 1, 2026*	38a-544(a)

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:

Agency Affected	Fund-Effect	FY 27 $	FY 28 $
State Comptroller - Fringe Benefits	Various - Potential Cost	67.3 million	130 million
State Comptroller - Fringe Benefits	Various - Indeterminate	See Below	See Below
UConn Health Ctr.	OF - Revenue Gain	See Below	See Below
UConn Health Ctr.	OF - Indeterminate	See Below	See Below

Note: Various=Various; OF=Other Funds

Municipal Impact:

Municipalities	Effect	FY 27 $	FY 28 $
Various Municipalities	Potential Cost	See Below	See Below
Various Municipalities	Indeterminate	See Below	See Below

Explanation

The bill makes various changes regarding health insurance and patient protection, including establishing a rebuttable presumption or utilization review, which would likely result in a cost of $67.3 million across various funds beginning in FY 27, annualized to $130 million in FY 28. The bill makes various other changes anticipated to result in the fiscal impacts described below.

Section 1 results in an indeterminate cost annually beginning in FY 27 to the state employee health plan (SEHP), municipalities on the state partnership plan (SPP), and UConn Health Center (UCHC). It requires health carriers and preferred provider networks that contract with

health care providers to pay equal reimbursement rates for certain outpatient services regardless of the facility where the services occur.

The impact to the SEHP and the SPP will depend on the rates set by health carriers and preferred provider networks. The bill does not specify these rates. The fiscal impact to UCHC will depend on: (1) the difference between the UCHC's current reimbursement rates in hospital-based settings and those set pursuant to the bill; and (2) the number of procedures performed.

Section 4 results in: (1) a potential cost annually beginning in FY 27 to the SEHP and the SPP; and (2) a potential revenue gain annually beginning in FY 27 to the UCHC. The section prohibits carriers from using software tools to automatically downcode or deny a health insurance claim without being reviewed by a clinical peer.

The potential cost to the SEHP and the SPP will depend on the extent to which more expensive and frequent claims impact premiums. The extent of the potential revenue gain to the UCHC will depend on: (1) the reimbursement gain that occurs by preventing downcoding, and (2) the number of health insurance claims paid out that would have otherwise been denied.

Sections 6 and 7 result in: (1) a potential cost to the state beginning in FY 27 of $60.5 million across various funds, annualized to $121 million in FY 28; (2) a potential cost to fully insured municipalities and those enrolled in the SPP; and (3) a potential revenue gain annually beginning in FY 27 to UCHC. The sections establish a rebuttable presumption that a health care service undergoing utilization review is medically necessary if ordered by a health care professional in the highest tier of their network.

The cost to the state is associated with increased pharmacy and medical utilization for the SEHP. Medical claims costs are expected to increase by approximately 20% as more services are deemed "medically necessary" resulting from the change in utilization review methodology. This annualized impact is estimated to be $92 million. The annualized

impact of the change in utilization review on pharmacy benefits is estimated to be $29 million, largely driven by costs related to specialty drugs.

Fully insured municipalities and those participating in the SPP are likely to see an increase in premiums to the extent carriers expect to see higher utilization of services. Municipalities enrolled in the SPP will likely see costs commensurate with the increase to the SEHP based on their enrollment.

The revenue gain to the UCHC will depend on the extent to which the rebuttable presumption results in an increase in insurance claims paid out.

Sections 8 and 9 result in: (1) a potential cost to the state beginning in FY 27 of $6.75 million across various funds, annualized to $9 million in FY 28 for increased premiums for the SEHP; and (2) a potential cost to fully insured municipalities and those enrolled in the SPP. The sections restrict the use of step therapy on prescription drugs used to treat disabling or life-threatening chronic diseases.

Step therapy is used as a cost management tool, and its prohibition for prescription drugs to treat disabling or life-threatening chronic diseases is likely to be reflected in higher premiums through an increased per member per month cost. These restrictions are estimated to increase costs related to the differential between the lower cost alternative and the drug available after step therapy, as well as overall higher prescription drug spend.

These sections also result in potential costs to various municipalities that either have fully insured health plans or participate in the SPP to the extent higher utilization and prescription drug costs increase plan premiums. The SPP would face costs commensurate with the increase to the SEHP based on their enrollment.

Additionally, **Section 2** clarifies "anti-steering" clauses by adding utilization management to the definition resulting in no fiscal impact.

Section 3 requires the Insurance Department to conduct a study concerning revisions to the insurance statutes, which results in no fiscal impact as the department has the expertise to meet the requirements.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

SB 342

AN ACT CONCERNING HEALTH COVERAGE.

TABLE OF CONTENTS:

necessary if it was ordered by a health care professional who is in the health carrier's highest network tier and acting within his or her scope of practice

§§ 8 & 9 — EXPANDING PROHIBITION ON STEP THERAPY

Prohibits individual and group insurers from requiring step therapy for prescription drugs used to treat all forms of cancer and any disabling or life-threatening chronic disease

SUMMARY

This bill contains provisions on a variety of health insurance topics, including the following:

1. site neutral provider reimbursement rules for outpatient services;
2. anti-steering clauses and utilization management;
3. an insurance commissioner study of statutes on excess insurance, the Health Care Cabinet, and off-site outpatient services;
4. algorithmic or automatic claim downcoding;
5. continuing health carrier (for example, insurer) and hospital provider contracts during contract disputes;
6. a rebuttable presumption that a health care service going through utilization or adverse determination review is medically necessary; and
7. the use of step therapy prescription drug protocols in certain circumstances.

A section-by-section analysis follows.

EFFECTIVE DATE: October 1, 2026, except provisions on (1) site neutral provider reimbursement rules take effect on July 1, 2026; (2) the insurance commissioner's study take effect upon passage; and (3) the rebuttable presumption that certain services are medically necessary take effect on January 1, 2027.

§ 1 — SITE NEUTRAL PROVIDER REIMBURSEMENT

Requires health carriers and preferred provider networks that contract with heath care providers to pay equal reimbursement rates for certain outpatient services to all providers in a geographic area and regardless of the facility where the services are provided

The bill requires health carriers and preferred provider networks that enter into, renew, or amend a contract with a health care provider on or after July 1, 2026, to include in the contract a provision requiring equal reimbursement rates for certain covered outpatient services:

1. for all providers in the same geographic region (as determined by the insurance commissioner), regardless of the provider's employer or affiliation, if the services are reimbursed on a fee-for-services basis or as a standardized bundle of benefits (for example, per diagnosis, condition, or procedure) and

2. regardless of the facility where the services are provided.

This applies to covered outpatient services that use a current procedural terminology evaluation and management (CPT E/M) code, current procedural terminology assessment and management (CPT A/M) code, telehealth code, or drug infusion code.

Additionally, the bill requires the (1) contracts to include a conspicuous statement that they comply with the bill's provisions and (2) insurance commissioner to adopt implementing regulations.

§ 2 — ANTI-STEERING CLAUSES

Clarifies that health carriers and health plan administrators may use utilization management tools to encourage enrollees to use certain hospitals or health systems by adding utilization management to the definition of anti-steering clauses

The bill specifically allows health carriers and health plan administrators to use utilization management tools to encourage enrollees to use certain hospitals and health systems (such as centers of excellence) by expanding the definition of anti-steering clauses.

By law, health care providers, health carriers, and health plan administrators cannot include anti-steering clauses in health care contracts. An "anti-steering clause" is any provision (including, under

the bill, utilization management provisions) in a health care contract that restricts health carriers or health plan administrators from encouraging enrollees to get services from a competing hospital or health system. Utilization management is generally the process by which an insurer manages the use of covered services, including prior authorization or step therapy protocols, among others.

§ 3 — STUDY OF INSURANCE STATUTE REVISIONS

Directs the insurance commissioner to study revisions to statutes including those on excess insurance, the Health Care Cabinet, and outpatient health services provided at a hospital-based facility that is off-site from the hospital campus

The bill directs the insurance commissioner to study revisions to the insurance statutes, including those on:

1. excess insurance (policies generally designed to supplement an underlying liability policy in the event of damage above a specified coverage amount);

2. the Health Care Cabinet (a committee within the Office of Health Strategy that advises the governor on issues related to federal health reform implementation and the development of an integrated health care system for the state, among other things); and

3. outpatient health services (including injections and infusions) provided at a hospital-based facility that is off-site from the hospital campus.

The commissioner must report the study results and any recommendations to the Insurance and Real Estate Committee by January 1, 2027.

§ 4 — DOWNCODING

Prohibits health carriers from using software, including artificial intelligence or algorithms, to automatically downcode or deny a claim without a clinical peer's review

The bill prohibits health carriers from using software, including artificial intelligence or algorithms, to automatically downcode or deny a claim without a clinical peer's review.

Under the bill, downcoding is an adjustment of a health benefit claim by an entity, including an insurer or preferred provider network, to a less complex or lower cost billing code to give a lower reimbursement to a health care provider than the provider's health care contract requires. A clinical peer is generally a physician or other health professional licensed in the same specialty as the treating provider.

§ 5 — CONTRACT CONTINUATION REQUIREMENT

Extends the contract continuation requirement for health carriers and hospitals in the case of a contract dispute or termination until the earlier of the contract dispute resolution date or the policyholder's renewal date

Under the bill, when a contract between a health carrier and a hospital (or the hospital's parent corporation or intermediary) is terminated or not renewed, both the carrier and hospital must abide by the terms of the expired contract until the earlier of the (1) date the contract dispute is resolved or (2) policyholder's renewal date. Under current law, the carrier and hospital must abide by the terms of the contract for 60 days after either the termination date or end of the contract period in the case of nonrenewal.

§§ 6 & 7 — MEDICAL NECESSITY REBUTTABLE PRESUMPTION

Establishes a rebuttable presumption that a health care service going through utilization or adverse determination review is medically necessary if it was ordered by a health care professional who is in the health carrier's highest network tier and acting within his or her scope of practice

The bill establishes a rebuttable presumption that a health care service undergoing utilization or adverse determination review is medically necessary if it was ordered by a health care professional who is in the health carrier's highest network tier and acting within his or her scope of practice. "Utilization review" is a process to determine if a service is covered under the health benefit plan. It evaluates the medical necessity, appropriateness, efficacy, or efficiency of health care services, health care procedures, or health care settings, and includes prospective, concurrent, or retrospective review (CGS § 38a-591a(39)). Adverse determination reviews are generally concerned with the factors relating to a benefit denial.

Under the bill, a health carrier or utilization review company acting

on the carrier's behalf has the burden of proving the health care service under utilization review is not medically necessary.

With respect to reviews of adverse determinations that were based on medical necessity, a health carrier may rebut the presumption that the service is medically necessary by reasonably substantiating to the clinical peer (health care professional) reviewing the adverse determination that the service is not medically necessary.

§§ 8 & 9 — EXPANDING PROHIBITION ON STEP THERAPY

Prohibits individual and group insurers from requiring step therapy for prescription drugs used to treat all forms of cancer and any disabling or life-threatening chronic disease

The bill limits a health carrier's use of step therapy. Step therapy is a protocol that generally requires patients to try less expensive prescription drugs before higher-cost drugs.

The bill prohibits certain individual and group health insurance policies or contracts from requiring the use of step therapy for prescription drugs used to treat (1) cancer generally and (2) disabling or life-threatening chronic diseases. (The bill does not define "disabling or life-threatening chronic diseases.") Current law, among other things, prohibits step therapy for drugs used to treat stage IV metastatic cancer, multiple sclerosis, or rheumatoid arthritis.

Under the bill, as under existing law, a patient's provider can deem step therapy clinically ineffective for the patient, at which point the health carrier must cover the drugs prescribed by the provider, if they are covered under the insurance policy or contract. If the provider does not consider the step therapy regimen to be ineffective or does not request an override as the law allows, the regimen may be continued.

The bill applies to individual and group health insurance policies or contracts that provide coverage for prescription drugs and are delivered, issued, renewed, amended, or continued by an insurer, hospital or medical service corporation, health care center (HMO), or other entity.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 9 Nay 4 (03/12/2026)