Insurance and Real Estate Committee
JOINT FAVORABLE REPORT

Bill No: SB-342 / Bill Status / Public Hearing Testimony
Title: AN ACT CONCERNING HEALTH COVERAGE.
Vote Date: 3/12/2026
Vote Action: Joint Favorable
PH Date: 3/3/2026
File No.:

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SPONSORS OF BILL:
Insurance and Real Estate Committee

REASONS FOR BILL:
This bill seeks to (1) require certain health insurers, preferred provider networks and other entities to include certain provisions in contracts with health care providers regarding reimbursement for certain covered health benefits, (2) clarify the definition of "anti-steering clause" under the general statutes, (3) require the Insurance Commissioner to conduct a study concerning various revisions to the insurance statutes, (4) change the time period that a health carrier and participating provider shall continue to abide by the terms of a contract under the general statutes, (5) prohibit a health carrier from using a software tool to downcode or deny certain health insurance claims, (6) establish a rebuttable presumption for purposes of the review of an adverse determination under the general statutes, and (7) prohibit certain health carriers from requiring step therapy for prescription drugs used to treat a chronic, disabling or life-threatening condition. Through this bill, the Committee hopes to facilitate access to healthcare coverage by ameliorating issues such as automated claim denials, excessive utilization review, and complications with the appeals process.

RESPONSE FROM ADMINISTRATION/AGENCY:
Kathleen Holt, Healthcare Advocate for the Office of the Healthcare Advocate (OHA): Ms. Holt makes several comments regarding different provisions of the bill. For the site-neutrality section, OHA supports the proposals, as they would address price disparities for covered services based on the provider and location of the services. Ms. Holt advises the Committee to include language that preserves the availability and access to services that could be compromised by these requirements. Regarding downcoding, OHA supports the intent but has reservations that the bill may inadvertently limit a carrier's ability to efficiently conduct clinical reviews or implement fraud, waste, abuse, and error programs. The Office suggests including clarifying language that would preserve a carrier's ability to implement clinical and reimbursement protocols and policies that ensure the coverage of medically necessary care while combating waste. Additionally, the Office supports the extension of the "cooling off" period to protect consumers when their provider unexpectedly leaves the insurer's provider network, and recommends that language be included to require insurers and providers to publish their contract termination dates. Moreover, the Office supports the modifications to the clinical utilization review process to require that health plans afford greater deference to the clinical decisions of providers. They regard this provision as a common-sense step towards addressing the high

frequency of utilization review denials, especially since more than half of the appeals initiated by consumers result in overturned denials. Lastly, the Office is supportive of the limitations regarding step therapy due to the risks that are included in the lengthy and repetitive step therapy process.

NATURE AND SOURCES OF SUPPORT:

Senator Martin Looney, President Pro Tempore, 11th District: Sen. Looney lends his support for certain sections of the bill and provides comments on others. He supports the site neutral reimbursement and anti-steering clause provisions, but has reservations regarding the study to be conducted by the Insurance Commissioner. The Healthcare Cabinet, in his view, should conduct the study, and he advises the Committee to amend this section to require that the Healthcare Cabinet research and create recommendations regarding ground ambulance surprise billing. Additionally, he urges the Committee to, "add a section to the bill that would cap the reimbursement rate for medications infused or injected at hospital owned off campus facilities at the Average Sales Price (ASP) plus 10 percent and to prohibit facility fees on these services (making clear that a medication administration charge is not a facility fee)." He expresses broad support for the remainder of the bill.

Multiple members of the public along with several medical field workers, including physiatrists, physicians, pediatricians, dermatologists, gastroenterologists, and surgeons, voice their support for Section 4 of this bill. They argue that is crucial because it addresses the issue of health insurers using artificial intelligence and algorithm-driven tools to deny patients care with very little human oversight. This downcoding also forces practitioner offices to allocate more staff time to appeals, documentation review, and follow-up, which takes time away from patient care. Additionally, they voice concern over how AI systems have issues with more complex cases and managing bias based on gender, race, ethnicity, and age. They stress that requiring insurers to use individualized clinical review instead of broad algorithms would reduce the problem of inappropriate and excessive downcoding, thereby preventing further harm to the patient through delays in urgently-needed care. The declining reimbursement and increased administrative burden it creates can also discourage physicians from entering or staying in complex specialities, thereby accelerating consolidation and reducing patient access to personalized care.
L. Anthony Cirillo, President of the American College of Emergency Physicians
Jessica Abellard, President of the CT Psychiatric Society
Henry Beecher, MD
Salvatore Del Prete, MD
Rod Acosta, MD
Jamie Alon, MD
John Grady-Benson, MD
Sarah Buckingham, MD
Erik Carlson, MD
Jill Denowitz, MD
Peter Hahn, MD
Andrew Garrett, MD
Connecticut ENT Society
Marjorie Garrett, MD
Cullen Griffith, MD
Jennifer Henkind, MD
Daniel Markowicz, MD
Jaclyn Munoz, MD
Frank Santoro, MD
Kenneth Thomas, MD
Mariam Hakim-Zargar, MD
John Whyte, MD
Aris Yannopoulos, MD
Simon Allentuch, Esq.

Michaela Childs
Marc Degregorio
Liz Dupont-Diehl, Associate Director of the CT Citizen Action Group
James FitzGibbons, MD
William Freudenthal, MD, Chair of the Emergency Department Practice Management Association
Ari Geller, MD and Managing Partner at Greater Hartford Nephrology
Jodie Gillon, President and CEO of BioCT
David Hass, MD
William Hines, MD
Matha Howard, MD
Barbara Kage, MD
David Levinson, MD
Violet Lin, MD
Ray Lorenzoni III, MD
Daniel Markowicz, MD
Robert McLean, MD
Seth Meskin, MD
Tom Miller, MD
Hartford County Medical Association
Connecticut College of Emergency Physicians
Connecticut Society of Eye Physicians
Connecticut Dermatology and Dermatologic Surgery Society
Connecticut Urology Society
Sujata Pendyala, MD
Remi Rosenberg, MD
Rachel Rothschild, MD
John Satterfield, MD
Anne Sebastian, MD
Miri Sami
JoAnn Smith, MD
Richard Stumacher, MD
Kenneth Thomas, MD
John Vaccino
Stacy Versailles, MD
Alexander Voldman
Megan Wolf, MD
Saryna Young, MD
Anthony Yoder, Co-Chair of the Health and Public Policy Committee with the CT Chapter of the American College of Physicians
Aleena Zia, MD

The Connecticut Hospital Association (CHA): The Association supports sections 4, 6, 7, 8, and 9. They recommended that the Committee broaden the provisions in sections 6 and 7 so that there is a presumption that care from any provider - not just high-tier providers - is presumed to be medically necessary.

Connecticut State Medical Society (CSMS): The Society expresses general support for the bill along with a few concerns and general comments. They express support for section 4 due to the administrative burden that automatic downcoding causes physicians, and this can negatively impact the retention of the physicians that our state trains. Regarding section 6, they stress the importance of the presumption of medical necessity because it prioritizes the medical expertise of practitioners over corporate cost-control judgments. For sections 8 and 9, CSMS argues that step therapies are an example of insurer-created barriers to care, which can be detrimental in high-risk and time-sensitive

clinical situations. They express reservations on section 1, stating that care delivery is nuanced and that different sites can have varying amounts of staff, infrastructure, equipment, and overhead. The definition of 'provider' is not included, which could create confusion regarding the types of medical professionals whose care falls under this provision. Moreover, they worry that because the Insurance Commissioner is not elected that their office is not the right entity to establish reimbursement rates. CSMS would like to be a part of the discussions surrounding this bill.

Lisa Trumble, CEO of the Southern New England Healthcare Organization (SoNE HEALTH): The Organization provides general support while urging the Committee to make adjustments that would prevent unintentionally expanding insurer power and undermining provider sustainability. They argue that it takes significant steps to curb inappropriate health insurer practices that deny or delay necessary care. Regarding section 1, they warn that state-mandated rate-setting would interfere with payment models and other incentives that improve efficiency and innovation. This poses a substantial financial risk to certain organizations while benefitting insurers. Moreover, they state that the "anti-steering clause" impedes providers' ability to guide patients to more cost-effective care. The extension of the contract terms is an additional component that they argue could increase insurers' bargaining power. They offer different language for the bill regarding contracting and emphasize that the Legislature should prioritize provider infrastructure over health plan profit margins.

Erin Smith, Director of State Government Affairs at Boehringer Ingelheim: Boehringer Ingelheim, a global pharmaceutical company that develops therapies in areas of high unmet medical need, supports this bill. They argue that sections 2, 6, and 7 work to expand patients' access to care. Additionally, they state that sections 8 and 9 are vital patient protections by placing sensible limits on step therapy requirements. They suggest that the Committee, "...explicitly clarify that Chronic Kidney Disease, serious lung conditions including Pulmonary Fibrosis and Bronchiectasis, and disabling eye conditions that can lead to blindness, such as Geographic Atrophy, Diabetic Retinopathy, and Diabetic Macular Edema, fall within the scope of 'disabling or life-threatening chronic diseases' under Sections 8 and 9."

Pamela Greenberg: Ms. Greenberg is a constituent with Crohn's Disease and Multiple Sclerosis, and supports sections 6 and 7 based on her experience with insurance carriers requiring step therapy. She voices frustration with the delays in treatment that she and other patients experience because of these insurance company policies.

Laura Gregory: Ms. Gregory is a constituent with Multiple Sclerosis who supports sections 6 through 9 because of the difficulties that she had with accessing medication due to the step therapy requirements. She states that, "Patients are not medical professionals, but we are experts in our own health. And doctors didn't go to medical school to do hours of paperwork on prescription appeals; when they prescribe something it is because they have discussed it with us and believe it is medically necessary."

Laura Hoch, Associate Vice President of State Advocacy & Policy for the National Multiple Sclerosis Society (NMSS): The NMSS states that the complications that multiple sclerosis patients face due to policies such as utilization management techniques and step therapy drive their support for this bill. They testify that, "When someone finds stability on a medication, it is critical to their health and safety that they remain on that medication uninterrupted unless the drug becomes contraindicated. The threat of facing step therapy and, as a result, delays in treatment at any point could lead to serious, irreversible disabling events."

Donald McMenemy: Mr. McMenemy supports this bill, citing his mother's complications with receiving coverage for a walking aid to help with her neurodegenerative disease. He states that her insurance carrier refuses to issue a single case agreement to the device manufacturer to guarantee payment,

and her prior authorization expires in April. These provisions thus create a barrier between patients and adequate care, and he stresses the urgency of his mother's condition.

Several individuals and organizations that provide mental health services express their support for sections 4, 6, and 7. They emphasize that it is critical to address the issue of automated systems overriding provider judgment, which can drive behavioral health clinicians out of networks. Regarding sections 6 and 7, they testify that behavioral health services are subject to prior authorization and utilization review at much higher rates than other types of medical services. Moreover, they echo the CT Parity Coalition's suggestion to require health insurance carriers to use medical necessity criteria that follow accepted standards of care which are recognized by nonprofit clinical specialty organizations. The behavioral health field is disproportionately affected by downcoding, utilization reviews, and prior authorization, which causes many clinicians to opt out of insurance panels, thereby limiting patient options and straining the mental healthcare system.
Monika Nugent, Manager of Public Policy at The CT Community Nonprofit Alliance (The Alliance)
Amanda Pasciucco, PhD
Brian Mulroy
Christian Damiana with the CT Parity Coalition
Thomas Burr, Public Policy Manager for the National Alliance on Mental Illness Connecticut (NAMI)
Jessica Abellard, President of the CT Psychiatric Society
Kirsten Pendergrass, Vice President of State Policy for Shatterproof
Maria Victoria Ramos, PsyD and Director of Professional Affairs for the CT Psychological Association
Jamie Rodriguez, Therapist and Advocacy Chair for the CT Association of Marriage and Family Therapy
Pyramid Healthcare: An Integrated Behavioral Healthcare System

Kathleen Silard, President of Stamford Health: Stamford Health supports several sections of the bill, specifically sections 4, 5, 6, 7, 8, and 9. They argue that section 4 recognizes the importance of clinical peer review, section 5 would allow for better continuity of care, sections 6 and 7 would rest the burden of proof on the insurer instead of the provider, and sections 8 and 9 would support those with life-threatening and disabling chronic illnesses.

Six anonymous testifiers expressed their support for this bill.

NATURE AND SOURCES OF OPPOSITION:

The Connecticut Hospital Association (CHA): The Association opposes section 1 and has concerns about sections 2 and 5. Regarding section 1, they state that this is unnecessary and could hinder hospitals and health systems from reaching underserved communities. They stress that hospitals are held to higher licensing and regulatory standards while also serving sicker, more vulnerable, and lower-income populations than independent physician offices. This section of the bill therefore does not consider the economic pressure that hospitals face and does not acknowledge the fundamental differences between hospital outpatient departments and other sites of care. Regarding section 2, CHA discusses their work in policy discussions on negotiations between commercial health insurance companies and healthcare providers. They worry that the change to the "anti-steering clause" is overly broad, which could negatively impact patient care. Lastly, while they understand the intent of section 5, CHA argues that it is administratively unworkable. They offer to discuss these sections with the Committee to determine a path forward.

Desmond Ebanks, Founder and Medical Director of Alternity Healthcare LLC: Mr. Ebanks states that he supports the intention of the bill, but that the mechanisms it uses are fundamentally flawed and will create more harm. Regarding section 1, he argues that it will trigger a substantial amount of payer audits, retroactive claim adjustments, and contested reimbursements that will exacerbate physician burnout through administrative burdens. A flat-rate reimbursement framework, for certain types of care, does not take into account the complexity levels of different types of doctor visits. This will result

in greater systemic scrutiny and retroactive downcode adjustments that will disincentivize providers from greater clinical engagement and taking on more medically complex patients. Regarding section 4, he says that the administrative burden will cause financial failure for small, independent, and community practices. Due to the impacts of these sections, he maintains that it will leave vulnerable populations with reduced access to care. With regard to section 3, he states that the study by the Insurance Commissioner should happen prior to, and not following, the enactment of the bill. He makes several suggestions, including the establishment of hard adjudication timelines, creation of meaningful downcoding accountability, requirement of transparent clinical peer credentials, and funding of administrative relief for smaller practices.

Sarah Geiger, Regional Director of State Affairs America's Health Insurance Plans (AHIP): The AHIP applauds the intent of the bill, but opposes the legislation as it is written. They state that while section 1 could help protect patients against higher hospital fees, they urge the Committee to adopt additional measures to address loopholes and express their concern regarding the overly prescriptive reimbursement requirements. The AHIP argues that limiting a carrier's ability to negotiate competitive reimbursement rates could make healthcare inaccessible for some patients and businesses. For section 4, they testify that prohibiting health plans from using certain programs to determine the accuracy of billing codes will undermine the insurer's ability to prevent abuse, which would then lead to companies having to pay inflated or incorrect claims that would increase premiums for consumers. Regarding sections 6, and 7, they worry that the rebuttable presumption standard creates a "no questions asked" approach even in situations where a utilization reviewer determines that there is a lack of medical necessity to avoid wasteful spending.

Sam Hallemeier, Senior Director of State Affairs for the Pharmaceutical Care Management Association (PCMA): The PCMA opposes this bill, in particular sections 6 and 7. They argue that step therapy and prior authorization ensure that patients are receiving the right medicine that is screened for safety, necessity, and lower cost alternatives. This bill would thus raise costs and put patient safety at risk.

Susan Halpin, Executive Director of the CT Association of Health Plans (CTAHP): The CTAHP opposes the bill. For section 1, they warn that it could increase total system costs, and instead recommend mandating the inclusion of the National Provider Identifier on claims. Regarding section 2, they express concern that it would inadvertently limit care management and value-based benefit plan design. Moreover, the scope of the study with the Insurance Commissioner necessitates three separate studies, which include actuarial, delivery modalities, and market considerations. Lastly, they state that sections 4 through 9 would be detrimental to the affordability of healthcare due to the operational complexity, administrative burden, and financial cost they would bring to insurers.

Kathleen Silard, President of Stamford Health: Stamford Health opposes sections 1 and 3 of the bill. They state that site neutral policies reduce payments for care and do not take into account the differences in maintenance costs and patient populations that different medical facilities have. This leads to some facilities bearing greater economic costs than others. The proposal regarding "anti-steering" is overly broad in their view and lacks clarity.

Reported by: Mia Giglietti **Date: 03/30/2026**