



Substitute House Bill No. 5377

Public Act No. 26-56

AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS.

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

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 Subsection (c) of section 38a-479b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

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

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

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

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

(D) Such organization paid a claim that should have been or was paid

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by a federal or state program; or

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

(2) (A) Such organization shall give at least thirty days' advance notice to a provider by [mail, electronic mail or facsimile] certified mail, return receipt requested, electronic mail to such electronic mail address designated by such provider or facsimile, or through a secure electronic provider portal or electronic clearinghouse used for claims or remittance communications, of the organization's cancellation, denial or demand for the return of full or partial payment pursuant to subdivision (1) of this subsection.

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

(C) Not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision, a provider may appeal such cancellation, denial or demand in accordance with the procedures provided by such organization, which shall include, but need not be limited to, an electronic appeal process. If any such organization fails to notify the provider of such organization's determination of such appeal not later than thirty business days after receipt of such appeal from such provider, such appeal shall be construed in favor of such provider. Any

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demand for the return of full or partial payment shall be stayed during the pendency of such appeal.

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

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

Sec. 2. (NEW) (*Effective January 1, 2027*) (a) For the purposes of this section, "health care provider" has the same meaning as provided in section 38a-477aa of the general statutes.

(b) (1) No insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing an individual or group health insurance policy in this state on or after January 1, 2027, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes, shall cancel, deny or demand the return of full or partial payment for an authorized covered service due to administrative or eligibility error, more than twelve months after the date of the receipt of a clean claim for such service, except if:

(A) Such insurer, center, society, corporation or other entity has a

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documented basis to believe that such claim was submitted fraudulently by such health care provider;

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

(C) Such insurer, center, society, corporation or other entity has paid the health care provider for such claim more than once;

(D) Such insurer, center, society, corporation or other entity paid a claim that should have been or was paid by a federal or state program; or

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

(2) (A) Such insurer, center, society, corporation or other entity shall give at least thirty days' advance notice to a health care provider by certified mail, return receipt requested, electronic mail to such electronic mail address designated by such health care provider or facsimile, or through a secure electronic health care provider portal or electronic clearinghouse used for claims or remittance communications, of the insurer's, center's, society's, corporation's or other entity's cancellation, denial or demand for the return of full or partial payment pursuant to subdivision (1) of this subsection.

(B) If such insurer, center, society, corporation or other entity

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

(C) Not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision, a health care provider may appeal such cancellation, denial or demand in accordance with the procedures provided by such insurer, center, society, corporation or other entity, which shall include, but need not be limited to, an electronic appeal process. If any such insurer, center, society, corporation or other entity fails to notify the health care provider of such insurer's, center's, society's, corporation's or other entity's determination of such appeal not later than thirty business days after receipt of such appeal from such health care provider, such appeal shall be construed in favor of such health care provider. Any demand for the return of full or partial payment shall be stayed during the pendency of such appeal.

(D) If there is no appeal or an appeal is denied, such health care provider may resubmit an adjusted claim, if applicable, to such insurer, center, society, corporation or other entity, not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision or the denial of the appeal, whichever is applicable, except that if a return of payment was demanded pursuant to subparagraph (C) of subdivision (1) of this subsection, such claim shall not be resubmitted.

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

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requirements.