OLR Bill Analysis

SB 342

AN ACT CONCERNING HEALTH COVERAGE.

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§§ 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)