



House of Representatives

General Assembly

File No. 245

February Session, 2026

Substitute House Bill No. 5377

House of Representatives, March 30, 2026

The Committee on Insurance and Real Estate reported through REP. WOOD of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS AND SITE OF SERVICE BILLING REQUIREMENTS.

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2 repealed and the following is substituted in lieu thereof (*Effective January*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 fifteen 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 [mail, electronic mail or facsimile] certified mail,
27 return receipt requested, electronic mail to such electronic mail address
28 designated by such provider or facsimile, or through a secure electronic
29 provider portal or electronic clearinghouse used for claims or remittance
30 communications, of the organization's cancellation, denial or demand
31 for the return of full or partial payment pursuant to subdivision (1) of
32 this subsection.

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

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

45 such provider, such appeal shall be construed in favor of such provider.
46 Any demand for the return of full or partial payment shall be stayed
47 during the pendency of such appeal.

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

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

61 Sec. 2. (NEW) (*Effective October 1, 2026*) (a) For the purposes of this
62 section:

63 (1) "Campus" and "hospital-based facility" have the same meanings
64 as provided in section 19a-508c of the general statutes; and

65 (2) "National provider identifier" means a standard, unique health
66 identifier for each health care provider issued by the Centers for
67 Medicare and Medicaid Services' National Plan and Provider
68 Enumeration System.

69 (b) On and after January 1, 2027, each hospital-based facility in this
70 state located off-site from a hospital campus shall submit with each
71 claim for reimbursement or payment for health care services provided
72 at such facility, such facility's national provider identifier and federal
73 tax identification number. Such national provider identifier and federal
74 tax identification number shall be (1) separate from any national
75 provider identifier and federal tax identification number issued to such

76 hospital campus, and (2) included on any claim for reimbursement or
77 payment for health care services provided at such facility, regardless of
78 whether such claim or reimbursement is filed or submitted by or
79 through a separate facility or hospital.

80 (c) On and after January 1, 2027, no health carrier shall be required to
81 reimburse or issue payment to a health care provider for a claim for a
82 health care item or service provided to a covered person at a hospital-
83 based facility in this state located off-site from a hospital campus, unless
84 such health care provider submits such claim for reimbursement or
85 payment to such health carrier in accordance with the provisions of
86 subsection (b) of this section.

87 (d) On and after January 1, 2027, no hospital-based facility in this state
88 located off-site from a hospital campus, or its designee, that fails to
89 submit a claim for reimbursement or payment to the health carrier in
90 accordance with the provisions of subsection (b) of this section shall
91 hold the covered person liable for payment of such claim for a health
92 care item or service.

93 (e) The Insurance Commissioner may adopt regulations, in
94 accordance with the provisions of chapter 54 of the general statutes, to
95 implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2027	38a-479b(c)
Sec. 2	October 1, 2026	New section

INS *Joint Favorable Subst.*

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 has no fiscal impact to the state or municipalities. It makes changes to laws regarding hospital billing requirements, claim payments, and appeals between health insurers and health care providers. These changes do not impact state and municipal health care plans, nor do they impact the UConn Health Center.

OLR Bill Analysis**sHB 5377*****AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS AND SITE OF SERVICE BILLING REQUIREMENTS.*****SUMMARY**

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

The bill also establishes billing requirements for hospital-based facilities that are located off-site from a hospital campus, primarily requiring them to submit their national provider identifier and federal tax identification number when they submit claims for reimbursement or payment, regardless of whether the claim is filed or submitted by or through a separate facility or hospital. It also authorizes the insurance commissioner to adopt implementing regulations.

Regarding provider claim payment and appeals, the bill:

1. reduces, from 18 months to 15 months, the time period after receiving a clean (complete and error-free) claim during which a contracting health organization may generally cancel, deny, or demand full or partial return of payment from a health care provider due to an administrative or eligibility error;
2. allows organizations to use a secure electronic provider portal or electronic clearinghouse used for claims or remittance communications to give providers the 30-day minimum advance notice of a payment cancellation, denial, or demand, notice required by law;

3. specifies that if the above notice is sent (a) by mail, it must be sent by certified mail, return receipt requested, or (b) by email, it must be sent to an email address the provider designates; and
4. requires the organization to notify the provider of its appeal determination within 12 business days after receiving the provider's appeal, otherwise the appeal must be construed in the provider's favor.

EFFECTIVE DATE: January 1, 2027, except the provision on site-of-service billing requirements is effective October 1, 2026

CLAIM 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 15 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, email, 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. The bill also gives organizations the option of providing this notice through a secure electronic provider portal or electronic clearinghouse used for claims or remittance communications.

Appeal

By law, a provider may appeal, in accordance with the organization's procedures, a payment cancellation, denial, or return demand within 30 days after receiving notice of it. Current law does not specify a mode for the appeal process. The bill explicitly requires organizations to have an electronic appeal process available to providers but allows them to have additional means to appeal available.

Further, the bill requires the organization to notify the provider of the appeal determination within 12 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.

SITE OF SERVICE BILLING REQUIREMENTS

The bill establishes site of service billing requirements for hospital-based facilities that are located off-site from a hospital campus.

Definitions

Under the bill, a "hospital-based facility" is one that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided.

A "campus" is (1) the physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, or (2) any other area that has been

determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus.

A "national provider identifier" is a standard, unique health identifier for each health care provider issued by the Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System.

Claim Submission and Reimbursement

Starting January 1, 2027, the bill specifically does the following:

1. requires off-site hospital-based facilities to include the facility's national provider identifier and federal tax identification number (see below) with each claim it submits for reimbursement or payment for health care services provided at the facility;
2. specifies that unless the provider submits the claim as described above, a health carrier must not be required to reimburse or pay the provider at an off-site hospital-based facility in Connecticut; and
3. prohibits any off-site hospital-based facility, or its designee, from holding the covered person under the claim liable for payment due to its failure to submit the claim to the health carrier in accordance with the bill.

National Provider Identifier and Federal Tax Identification Number

Under the bill, the national provider identifier and federal tax ID number a facility provides must be separate from the identifier or ID number issued to the hospital campus. They must also be included on any claim for reimbursement or payment for health care services provided at the facility, regardless of whether the claim or reimbursement is filed or submitted by or through a separate facility or hospital.

BACKGROUND

Related Bill

SB 341, favorably reported by the Insurance and Real Estate Committee, has similar provisions on (1) provider payment, cancellation, denial, and return and (2) the appeal determination notice.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 13 Nay 0 (03/12/2026)