



General Assembly

February Session, 2026

***Raised Bill No. 5377***

LCO No. 2272



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

***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2 repealed and the following is substituted in lieu thereof (*Effective January*  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 certified mail, return receipt requested, electronic  
27 mail to such electronic mail address designated by such provider or  
28 facsimile of the organization's cancellation, denial or demand for the  
29 return of full or partial payment pursuant to subdivision (1) of this  
30 subsection.

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

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

45 the pendency of such appeal.

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

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

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

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

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

67 (b) On and after January 1, 2027, each hospital-based facility in this  
68 state located off-site from a hospital campus shall submit with each  
69 claim for reimbursement or payment for health care services provided  
70 at such facility, such facility's national provider identifier and federal  
71 tax identification number. Such national provider identifier and federal  
72 tax identification number shall be (1) separate from any national  
73 provider identifier and federal tax identification number issued to such  
74 hospital campus, and (2) included on any claim for reimbursement or

75 payment for health care services provided at such facility, regardless of  
76 whether such claim or reimbursement is filed or submitted by or  
77 through a separate facility or hospital.

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

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

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

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

**Statement of Purpose:**

To: (1) Shorten the time period that health carriers may cancel, deny or demand the return of payment from health care providers and to require that health carriers establish an electronic appeal process; and (2) require hospital-based facilities to submit such facility's national provider identifier and tax identification number with each claim for reimbursement.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*