



General Assembly

Substitute Bill No. 5377

February Session, 2026



**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2 repealed and the following is substituted in lieu thereof (*Effective January*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	<i>January 1, 2027</i>	38a-479b(c)
Sec. 2	<i>October 1, 2026</i>	New section

INS *Joint Favorable Subst.*