General Assembly

February Session, 2026

Raised Bill No. 341

LCO No. **2246**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

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 Subsection (c) of section 38a-479b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):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 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 <u>certified</u> mail, <u>return receipt requested,</u> electronic mail <u>to such electronic mail address designated by such provider</u> or facsimile 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. <u>If any such organization fails to notify the provider of such organization's determination on such appeal not later than fifteen business days after receipt of such appeal from such provider, such appeal shall be construed in favor of such provider.</u> Any demand for the return of full or partial payment shall be stayed during the pendency of such appeal.

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2027*	38a-479b(c)

Statement of Purpose:

To 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.

[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.]