General Assembly

Raised Bill No. 342

February Session, 2026

LCO No. **2248**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING HEALTH COVERAGE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2026*) (a) Each insurer, health care center, hospital service corporation, medical service corporation, preferred provider network or other entity that enters into, renews or amends a contract with a health care provider on or after July 1, 2026, to provide covered benefits to insureds or enrollees in this state shall include in such contract:

(1) A provision requiring such insurer, health care center, hospital service corporation, medical service corporation, preferred provider network or other entity to:

(A) Reimburse the contracting health care provider for a covered outpatient benefit that uses a current procedural terminology evaluation and management (CPT E/M) code, current procedural terminology assessment and management (CPT A/M) code, telehealth codes or drug infusion code in an amount that does not vary based on the facility where the contracting health care provider provides such

16 benefit; and

17 (B) Use equal reimbursement rates for all contracting health care
18 providers in the same geographic region, as determined by the
19 Insurance Commissioner and regardless of the employer or affiliation of
20 any contracting health care provider, for each covered outpatient benefit
21 described in subparagraph (A) of this subdivision if the reimbursement
22 for such covered outpatient benefit is made on a fee-for-benefit basis or
23 on the basis of bundled benefits per diagnosis, condition, procedure or
24 another standardized bundle of health care benefits; and

25 (2) A conspicuous statement that such contract complies with the
26 provisions of subdivision (1) of this subsection.

27 (b) The Insurance Commissioner shall adopt regulations, in
28 accordance with the provisions of chapter 54 of the general statutes, to
29 implement the provisions of this section.

30 Sec. 2. Subdivision (2) of subsection (a) of section 38a-477i of the
31 general statutes is repealed and the following is substituted in lieu
32 thereof (*Effective October 1, 2026*):

33 (2) "Anti-steering clause" means any provision<u>, including, but not</u>
34 <u>limited to, utilization management provisions,</u> in a health care contract
35 that restricts the ability of the health carrier or health plan administrator
36 from encouraging an enrollee to obtain a health care service from a
37 competitor of a hospital or health system, including offering incentives
38 to encourage enrollees to utilize specific health care providers such as
39 centers of excellence or any other pay-for-performance program;

40 Sec. 3. (*Effective from passage*) The Insurance Commissioner shall
41 conduct a study concerning various revisions to the insurance statutes,
42 including, but not limited to, statutes concerning (1) excess insurance,
43 (2) the Health Care Cabinet, and (3) outpatient health care services,
44 including, injections and infusions, provided at a hospital-based facility
45 located off-site from a hospital campus. Not later than January 1, 2027,

46 the commissioner shall submit a report, in accordance with the
47 provisions of section 11-4a of the general statutes, to the joint standing
48 committee of the General Assembly having cognizance of matters
49 relating to insurance on the results and recommendations of such study.

50 Sec. 4. (NEW) (*Effective October 1, 2026*) (a) For purposes of this
51 section, "clinical peer" has the same meaning as provided in section 38a-
52 591a of the general statutes, "health carrier" has the same meaning as
53 provided in section 38a-1080 of the general statutes and "downcode"
54 means any adjustment of a health benefit claim by any insurer, health
55 care center, hospital service corporation, medical service corporation,
56 preferred provider network or other entity to a less complex or lower
57 cost billing code in order to provide a lower reimbursement to a health
58 care provider for such health benefit claim than is required for the actual
59 service performed pursuant to such contract between such health care
60 provider and such entity.

61 (b) No health carrier shall use a software tool, including, but not
62 limited to, artificial intelligence or an algorithm, to automatically
63 downcode or deny a health insurance claim submitted by a health care
64 provider without review by a clinical peer.

65 Sec. 5. Subparagraph (C) of subdivision (1) of subsection (g) of section
66 38a-472f of the general statutes is repealed and the following is
67 substituted in lieu thereof (*Effective October 1, 2026*):

68 (C) For each contract entered into, renewed, amended or continued
69 on or after July 1, 2023, between a health carrier and a participating
70 provider that is a hospital, as defined in section 38a-493, or a parent
71 corporation of a hospital or an intermediary of a hospital, if the contract
72 is not renewed or is terminated by either the health carrier or the
73 participating provider, the health carrier and the participating provider
74 shall continue to abide by the terms of such contract, including
75 reimbursement terms for all health care services and provisions
76 provided under such contract, **[**for a period of sixty days from the date

77 of termination or, in the case of a nonrenewal, from the end of the
78 contract period. Except as otherwise agreed between such health carrier
79 and such participating provider, the reimbursement terms of any
80 contract entered into by such health carrier and such participating
81 provider during said sixty-day period shall be retroactive to the date of
82 termination or, in the case of a nonrenewal, the end date of the contract
83 period. This subparagraph shall not apply if the health carrier and
84 participating provider agree, in writing, to the termination or
85 nonrenewal of the contract and the health carrier and participating
86 provider provide the notices required under subparagraphs (A) and (B)
87 of this subdivision**]** until the earlier of the date the dispute is resolved
88 or the policyholder's renewal date.

89 Sec. 6. Subdivision (2) of subsection (a) of section 38a-591c of the
90 general statutes is amended by adding subparagraph (D) as follows
91 (*Effective January 1, 2027*):

92 (NEW) (D) For each utilization review of a health care service ordered
93 by a provider in the highest tier or level of the health carrier's tiered
94 network, there shall be a rebuttable presumption that such health care
95 service under review is medically necessary if such service was ordered
96 by a provider in the highest tier or level of a health carrier's tiered
97 network acting within such provider's scope of practice. A health
98 carrier, or any utilization review company or designee of a health carrier
99 that performs utilization review on behalf of the health carrier, shall
100 have the burden of proving that a health care service ordered by a
101 provider in the highest tier or level of such health carrier's tiered
102 network is not medically necessary. For purposes of this subparagraph,
103 "tiered network" has the same meaning as provided in section 38a-472f,
104 as amended by this act.

105 Sec. 7. Subsection (c) of section 38a-591e of the general statutes is
106 repealed and the following is substituted in lieu thereof (*Effective January*
107 *1, 2027*):

108 (c) (1) (A) When conducting a review of an adverse determination
109 under this section, the health carrier shall ensure that such review is
110 conducted in a manner to ensure the independence and impartiality of
111 the clinical peer or peers involved in making the review decision.

112 (B) If the adverse determination involves utilization review, the
113 health carrier shall designate an appropriate clinical peer or peers to
114 review such adverse determination. Such clinical peer or peers shall not
115 have been involved in the initial adverse determination.

116 (C) (i) For each review of an adverse determination under this section
117 for a health care service ordered by a provider in the highest tier or level
118 of the health carrier's tiered network, there shall be a rebuttable
119 presumption that each health care service under review is medically
120 necessary if such service was ordered by a provider in the highest tier
121 or level of such health carrier's tiered network acting within such
122 provider's scope of practice. The health carrier may rebut such
123 presumption by reasonably substantiating to the clinical peer or peers
124 conducting the review under this section that such service is not
125 medically necessary. For purposes of this clause, "tiered network" has
126 the same meaning as provided in section 38a-472f, as amended by this
127 act.

128 (ii) The clinical peer or peers conducting a review under this section
129 shall take into consideration all comments, documents, records and
130 other information relevant to the covered person's benefit request that
131 is the subject of the adverse determination under review, that are
132 submitted by the covered person or the covered person's authorized
133 representative, regardless of whether such information was submitted
134 or considered in making the initial adverse determination.

135 (D) Prior to issuing a decision, the health carrier shall provide free of
136 charge, by facsimile, electronic means or any other expeditious method
137 available, to the covered person or the covered person's authorized
138 representative, as applicable, any new or additional documents,

139 communications, information and evidence relied upon and any new or
140 additional scientific or clinical rationale used by the health carrier in
141 connection with the grievance. Such documents, communications,
142 information, evidence and rationale shall be provided sufficiently in
143 advance of the date the health carrier is required to issue a decision to
144 permit the covered person or the covered person's authorized
145 representative, as applicable, a reasonable opportunity to respond prior
146 to such date.

147 (2) If the review under subdivision (1) of this subsection is an
148 expedited review, all necessary information, including the health
149 carrier's decision, shall be transmitted between the health carrier and the
150 covered person or the covered person's authorized representative, as
151 applicable, by telephone, facsimile, electronic means or any other
152 expeditious method available.

153 (3) If the review under subdivision (1) of this subsection is an
154 expedited review of a grievance involving an adverse determination of
155 a concurrent review request, pursuant to 45 CFR 147.136, as amended
156 from time to time, the treatment shall be continued without liability to
157 the covered person until the covered person has been notified of the
158 review decision.

159 Sec. 8. Subsection (a) of section 38a-510 of the 2026 supplement to the
160 general statutes is repealed and the following is substituted in lieu
161 thereof (*Effective October 1, 2026*):

162 (a) No insurance company, hospital service corporation, medical
163 service corporation, health care center or other entity delivering, issuing
164 for delivery, renewing, amending or continuing an individual health
165 insurance policy or contract that provides coverage for prescription
166 drugs may:

167 (1) Require any person covered under such policy or contract to
168 obtain prescription drugs from a mail order pharmacy as a condition of
169 obtaining benefits for such drugs; or

170 (2) Require, if such insurance company, hospital service corporation,
171 medical service corporation, health care center or other entity uses step
172 therapy for such drugs, the use of step therapy (A) for any prescribed
173 drug for longer than thirty days, (B) for a prescribed drug for cancer
174 treatment **[**for an insured who has been diagnosed with stage IV
175 metastatic cancer, multiple sclerosis or rheumatoid arthritis, provided
176 such prescribed drug is in compliance with approved federal Food and
177 Drug Administration indications**]** <u>or for the treatment of disabling or</u>
178 <u>life-threatening chronic diseases</u>, or (C) for the treatment of
179 schizophrenia, major depressive disorder or bipolar disorder, as defined
180 in the most recent edition of the American Psychiatric Association's
181 "Diagnostic and Statistical Manual of Mental Disorders".

182 (3) At the expiration of the time period specified in subparagraph (A)
183 of subdivision (2) of this subsection or for a prescribed drug described
184 in subparagraph (B) or (C) of subdivision (2) of this subsection, an
185 insured's treating health care provider may deem such step therapy
186 drug regimen clinically ineffective for the insured, at which time the
187 insurance company, hospital service corporation, medical service
188 corporation, health care center or other entity shall authorize
189 dispensation of and coverage for the drug prescribed by the insured's
190 treating health care provider, provided such drug is a covered drug
191 under such policy or contract. If such provider does not deem such step
192 therapy drug regimen clinically ineffective or has not requested an
193 override pursuant to subdivision (1) of subsection (b) of this section,
194 such drug regimen may be continued. For purposes of this section, "step
195 therapy" means a protocol or program that establishes the specific
196 sequence in which prescription drugs for a specified medical condition
197 are to be prescribed.

198 Sec. 9. Subsection (a) of section 38a-544 of the 2026 supplement to the
199 general statutes is repealed and the following is substituted in lieu
200 thereof (*Effective October 1, 2026*):

201 (a) No insurance company, hospital service corporation, medical

service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing a group health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy (A) for any prescribed drug for longer than thirty days, (B) for a prescribed drug for cancer treatment **[**for an insured who has been diagnosed with stage IV metastatic cancer, multiple sclerosis or rheumatoid arthritis, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications**]** <u>or for the treatment of disabling or life-threatening chronic diseases</u>, or (C) for the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) or (C) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step

234 therapy" means a protocol or program that establishes the specific
235 sequence in which prescription drugs for a specified medical condition
236 are to be prescribed.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2026*	New section
Sec. 2	*October 1, 2026*	38a-477i(a)(2)
Sec. 3	*from passage*	New section
Sec. 4	*October 1, 2026*	New section
Sec. 5	*October 1, 2026*	38a-472f(g)(1)(C)
Sec. 6	*January 1, 2027*	38a-591c(a)(2)(D)
Sec. 7	*January 1, 2027*	38a-591e(c)
Sec. 8	*October 1, 2026*	38a-510(a)
Sec. 9	*October 1, 2026*	38a-544(a)

Statement of Purpose:

To: (1) require certain health insurers, preferred provider networks and other entities to include certain provisions in contracts with health care providers regarding reimbursement for certain covered health benefits, (2) clarify the definition of "anti-steering clause" under section 38a-477i of the general statutes, (3) require the Insurance Commissioner to conduct a study concerning various revisions to the insurance statutes, (4) change the time period that a health carrier and participating provider shall continue to abide by the terms of a contract under section 38a-472f of the general statutes, (5) prohibit a health carrier from using a software tool to downcode or deny certain health insurance claims, (6) establish a rebuttable presumption for purposes of the review of an adverse determination under section 38a-591e of the general statutes, and (7) prohibit certain health carriers from requiring step therapy for prescription drugs used to treat a chronic, disabling or life-threatening condition.

[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.]