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

benefit; and

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

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

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

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 Subdivision (2) of subsection (a) of section 38a-477i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

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

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

provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance on the results and recommendations of such study.

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

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

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

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

and such participating provider, the reimbursement terms of any contract entered into by such health carrier and such participating provider during said sixty-day period shall be retroactive to the date of termination or, in the case of a nonrenewal, the end date of the contract period. This subparagraph shall not apply if the health carrier and participating provider agree, in writing, to the termination or nonrenewal of the contract and the health carrier and participating provider provide the notices required under subparagraphs (A) and (B) of this subdivision**]** until the earlier of the date the dispute is resolved or the policyholder's renewal date.

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

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

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

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of

the clinical peer or peers involved in making the review decision.

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

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

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

(D) Prior to issuing a decision, the health carrier shall provide free of charge, by facsimile, electronic means or any other expeditious method available, to the covered person or the covered person's authorized representative, as applicable, any new or additional documents, communications, information and evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such documents, communications, information, evidence and rationale shall be provided sufficiently in

advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, a reasonable opportunity to respond prior to such date.

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

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

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

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing an individual 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**]** or for the treatment of disabling or life-threatening chronic diseases, 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 therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

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

(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**]** or for the treatment of disabling or life-threatening chronic diseases, 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 therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition 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)

INS *Joint Favorable*

APP *Joint Favorable*

JUD *Joint Favorable*