



General Assembly

Amendment

February Session, 2026

LCO No. 4096



Offered by:
SEN. LOONEY, 11th Dist.

To: Senate Bill No. 342

File No. 223

Cal. No. 178

"AN ACT CONCERNING HEALTH COVERAGE."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. (NEW) (*Effective January 1, 2027*) (a) For the purposes of
4 this section:

5 (1) "Campus", "hospital" and "health system" have the same meanings
6 as provided in section 19a-508c of the general statutes; and

7 (2) "Infusion center" means a site that offers intravenous infusions
8 and intramuscular or subcutaneous injections of medications, fluids or
9 biological products for complex medical conditions that may include,
10 but are not limited to, cancer and autoimmune diseases.

11 (b) Any hospital or health system that schedules a patient for any
12 infusion or injection service performed at a hospital-based outpatient
13 infusion center located outside the hospital campus shall, at the time of
14 scheduling, provide such patient with a written notice that such patient

15 may incur financial liability that is greater than such patient may incur
16 if the service is provided at a non-hospital-based infusion center.

17 Sec. 2. (NEW) (*Effective January 1, 2027*) (a) For the purposes of this
18 section:

19 (1) "Campus", "hospital" and "health system" have the same meanings
20 as provided in section 19a-508c of the general statutes; and

21 (2) "Infusion center" means a site that offers intravenous infusions
22 and intramuscular or subcutaneous injections of medications, fluids or
23 biological products for complex medical conditions that may include,
24 but are not limited to, cancer and autoimmune diseases.

25 (b) Each insurer, health care center, hospital service corporation,
26 medical service corporation, fraternal benefit society or other entity, that
27 delivers, issues for delivery, renews, amends or continues an individual
28 or group health insurance policy in this state providing coverage of the
29 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
30 of the general statutes or utilization review company performing
31 utilization review for such insurer, center, corporation, society or entity,
32 that issues prior authorization for, or precertifies, any infusion or
33 injection service to be performed at an infusion center, on or after
34 January 1, 2027, shall, at the time of issuing such prior authorization or
35 precertification for any such service, provide the covered person with
36 written notice that if such service is performed at any hospital-based
37 outpatient infusion center located outside the hospital campus, such
38 covered person may incur financial liability that is greater than the
39 covered person may incur if such service is provided at a non-hospital-
40 based infusion center.

41 Sec. 3. Subdivision (2) of subsection (a) of section 38a-477i of the
42 general statutes is repealed and the following is substituted in lieu
43 thereof (*Effective October 1, 2026*):

44 (2) "Anti-steering clause" means any provision, including, but not
45 limited to, utilization management provisions, in a health care contract

46 that restricts the ability of the health carrier or health plan administrator
47 from encouraging an enrollee to obtain a health care service from a
48 competitor of a hospital or health system, including offering incentives
49 to encourage enrollees to utilize specific health care providers such as
50 centers of excellence or any other pay-for-performance program;

51 Sec. 4. (*Effective from passage*) (a) As used in this section, (1) "facility
52 fee" has the same meaning as provided in section 19a-508c of the general
53 statutes, and (2) "infusion center" means a site that offers intravenous
54 infusions and intramuscular or subcutaneous injections of medications,
55 fluids or biological products for complex medical conditions that may
56 include, but are not limited to, cancer and autoimmune diseases.

57 (b) The Health Care Cabinet established pursuant to section 19a-725
58 of the general statutes shall conduct a study of (1) potential methods to
59 lower costs associated with infusion and injection services performed at
60 hospital-based outpatient facilities located outside the hospital campus,
61 (2) appropriate patient protections for stop-loss insurance policies used
62 in conjunction with self-funded employee health benefit plans, and (3)
63 surprise billing practices involving ground ambulance services.

64 (c) Not later than January 1, 2027, the Health Care Cabinet shall
65 submit a report, in accordance with the provisions of section 11-4a of the
66 general statutes, to the joint standing committee of the General
67 Assembly having cognizance of matters relating to insurance on the
68 results and recommendations of such study. With respect to the
69 provisions of subdivision (1) of subsection (b) of this section, the report
70 shall include, but need not be limited to, recommendations concerning:

71 (1) Whether rates of payment for services performed at an infusion
72 center should be set at not more than ten per cent above the Medicare
73 average sales price calculated in accordance with 42 CFR 414.904, as
74 amended from time to time, or a different reimbursement rate payable
75 under Medicare; and

76 (2) Whether a facility fee for services performed at an infusion center

77 should be prohibited.

78 Sec. 5. (NEW) (*Effective October 1, 2026*) (a) For purposes of this
79 section, "clinical peer" has the same meaning as provided in section 38a-
80 591a of the general statutes, "health carrier" has the same meaning as
81 provided in section 38a-1080 of the general statutes and "downcode"
82 means any adjustment of a health benefit claim by any insurer, health
83 care center, hospital service corporation, medical service corporation,
84 fraternal benefit society or other entity to a less complex or lower cost
85 billing code in order to provide a lower reimbursement to a health care
86 provider for such health benefit claim than is required for the actual
87 service performed pursuant to such contract between such health care
88 provider and such insurer, center, corporation society or other entity.

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

93 (c) Any violation of this section by a health carrier shall be deemed
94 an unfair or deceptive insurance practice under section 38a-816 of the
95 general statutes, as amended by this act.

96 Sec. 6. Section 38a-816 of the general statutes is amended by adding
97 subsection (27) as follows (*Effective October 1, 2026*):

98 (NEW) (27) Any violation of section 5 of this act.

99 Sec. 7. Subparagraph (C) of subdivision (1) of subsection (g) of section
100 38a-472f of the general statutes is repealed and the following is
101 substituted in lieu thereof (*Effective July 1, 2026*):

102 (C) For each contract entered into, renewed, amended or continued
103 on or after July 1, [2023] 2026, between a health carrier and a
104 participating provider that is a hospital, as defined in section 38a-493, or
105 a parent corporation of a hospital or an intermediary of a hospital, if the
106 contract is not renewed or is terminated by either the health carrier or

107 the participating provider, the health carrier and the participating
108 provider shall continue to abide by the terms of such contract, including
109 reimbursement terms for all health care services and provisions
110 provided under such contract, [for a period of sixty days from the date
111 of termination or, in the case of a nonrenewal, from the end of the
112 contract period. Except as otherwise agreed between such health carrier
113 and such participating provider, the reimbursement terms of any
114 contract entered into by such health carrier and such participating
115 provider during said sixty-day period shall be retroactive to the date of
116 termination or, in the case of a nonrenewal, the end date of the contract
117 period. This subparagraph shall not apply if the health carrier and
118 participating provider agree, in writing, to the termination or
119 nonrenewal of the contract and the health carrier and participating
120 provider provide the notices required under subparagraphs (A) and (B)
121 of this subdivision] until the earlier of the date the dispute is resolved
122 or the policyholder's renewal date.

123 Sec. 8. Subdivision (2) of subsection (a) of section 38a-591c of the
124 general statutes is amended by adding subparagraph (D) as follows
125 (*Effective January 1, 2027*):

126 (NEW) (D) For each utilization review of a health care service ordered
127 by a health care provider participating in the tier or level of the health
128 carrier's tiered network with the lowest cost-sharing, there shall be a
129 rebuttable presumption that such health care service under review is
130 medically necessary if such service was ordered by such health care
131 provider acting within such health care provider's professional scope of
132 practice. Any utilization review company or designee of a health carrier
133 that performs utilization review on behalf of the health carrier, shall
134 have the burden of proving that any such health care service ordered by
135 a health care provider participating in the tier or level of the health
136 carrier's tiered network with the lowest cost-sharing is not medically
137 necessary. For purposes of this subparagraph, "tiered network" has the
138 same meaning as provided in section 38a-472f, as amended by this act.

139 Sec. 9. Subsection (c) of section 38a-591e of the general statutes is

140 repealed and the following is substituted in lieu thereof (*Effective January*
141 *1, 2027*):

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

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

150 (C) (i) To effectuate the rebuttable presumption pursuant to
151 subparagraph (D) of subdivision (2) of subsection (a) of section 38a-591c,
152 as amended by this act, the health carrier may rebut such presumption
153 by substantiating by clear and convincing evidence to the clinical peer
154 or peers conducting the review pursuant to the provisions of this section
155 that such health care service is not medically necessary.

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

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

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

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

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

187 Sec. 10. Subsection (a) of section 38a-510 of the 2026 supplement to
188 the general statutes is repealed and the following is substituted in lieu
189 thereof (*Effective October 1, 2026*):

190 (a) No insurance company, hospital service corporation, medical
191 service corporation, health care center or other entity delivering, issuing
192 for delivery, renewing, amending or continuing an individual health
193 insurance policy or contract that provides coverage for prescription
194 drugs may:

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

198 (2) Require, if such insurance company, hospital service corporation,
199 medical service corporation, health care center or other entity uses step
200 therapy for such drugs, the use of step therapy (A) for any prescribed
201 drug for longer than thirty days, (B) for a prescribed drug for cancer

202 treatment [for an insured who has been diagnosed with stage IV
203 metastatic cancer, multiple sclerosis or rheumatoid arthritis, provided
204 such prescribed drug is in compliance with approved federal Food and
205 Drug Administration indications] or for the treatment of a disabling or
206 life-threatening chronic disease, or (C) for the treatment of
207 schizophrenia, major depressive disorder or bipolar disorder, as defined
208 in the most recent edition of the American Psychiatric Association's
209 "Diagnostic and Statistical Manual of Mental Disorders".

210 (3) At the expiration of the time period specified in subparagraph (A)
211 of subdivision (2) of this subsection or for a prescribed drug described
212 in subparagraph (B) or (C) of subdivision (2) of this subsection, an
213 insured's treating health care provider may deem such step therapy
214 drug regimen clinically ineffective for the insured, at which time the
215 insurance company, hospital service corporation, medical service
216 corporation, health care center or other entity shall authorize
217 dispensation of and coverage for the drug prescribed by the insured's
218 treating health care provider, provided such drug is a covered drug
219 under such policy or contract. If such provider does not deem such step
220 therapy drug regimen clinically ineffective or has not requested an
221 override pursuant to subdivision (1) of subsection (b) of this section,
222 such drug regimen may be continued. For purposes of this section, "step
223 therapy" means a protocol or program that establishes the specific
224 sequence in which prescription drugs for a specified medical condition
225 are to be prescribed.

226 Sec. 11. Subsection (a) of section 38a-544 of the 2026 supplement to
227 the general statutes is repealed and the following is substituted in lieu
228 thereof (*Effective October 1, 2026*):

229 (a) No insurance company, hospital service corporation, medical
230 service corporation, health care center or other entity delivering, issuing
231 for delivery, renewing, amending or continuing a group health
232 insurance policy or contract that provides coverage for prescription
233 drugs may:

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

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

249 (3) At the expiration of the time period specified in subparagraph (A)
250 of subdivision (2) of this subsection or for a prescribed drug described
251 in subparagraph (B) or (C) of subdivision (2) of this subsection, an
252 insured's treating health care provider may deem such step therapy
253 drug regimen clinically ineffective for the insured, at which time the
254 insurance company, hospital service corporation, medical service
255 corporation, health care center or other entity shall authorize
256 dispensation of and coverage for the drug prescribed by the insured's
257 treating health care provider, provided such drug is a covered drug
258 under such policy or contract. If such provider does not deem such step
259 therapy drug regimen clinically ineffective or has not requested an
260 override pursuant to subdivision (1) of subsection (b) of this section,
261 such drug regimen may be continued. For purposes of this section, "step
262 therapy" means a protocol or program that establishes the specific
263 sequence in which prescription drugs for a specified medical condition
264 are to be prescribed."

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>January 1, 2027</i>	New section
Sec. 2	<i>January 1, 2027</i>	New section
Sec. 3	<i>October 1, 2026</i>	38a-477i(a)(2)
Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>October 1, 2026</i>	New section
Sec. 6	<i>October 1, 2026</i>	38a-816(27)
Sec. 7	<i>July 1, 2026</i>	38a-472f(g)(1)(C)
Sec. 8	<i>January 1, 2027</i>	38a-591c(a)(2)(D)
Sec. 9	<i>January 1, 2027</i>	38a-591e(c)
Sec. 10	<i>October 1, 2026</i>	38a-510(a)
Sec. 11	<i>October 1, 2026</i>	38a-544(a)