



House of Representatives

File No. 722

General Assembly

February Session, 2026

(Reprint of File No. 245)

Substitute House Bill No. 5377
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 27, 2026

AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS.

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2 repealed and the following is substituted in lieu thereof (*Effective January*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 twelve 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 thirty business days after receipt of such appeal from such

45 provider, such appeal shall be construed in favor of such provider. Any
46 demand for the return of full or partial payment shall be stayed during
47 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 January 1, 2027*) (a) For the purposes of this
62 section, "health care provider" has the same meaning as provided in
63 section 38a-477aa of the general statutes.

64 (b) (1) No insurer, health care center, fraternal benefit society,
65 hospital service corporation, medical service corporation or other entity
66 delivering, issuing for delivery, renewing, amending or continuing an
67 individual or group health insurance policy in this state on or after
68 January 1, 2027, providing coverage of the type specified in subdivisions
69 (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes, shall
70 cancel, deny or demand the return of full or partial payment for an
71 authorized covered service due to administrative or eligibility error,
72 more than twelve months after the date of the receipt of a clean claim
73 for such service, except if:

74 (A) Such insurer, center, society, corporation or other entity has a
75 documented basis to believe that such claim was submitted fraudulently
76 by such health care provider;

77 (B) The health care provider did not bill appropriately for such claim
78 based on the documentation or evidence of what medical service was
79 actually provided;

80 (C) Such insurer, center, society, corporation or other entity has paid
81 the health care provider for such claim more than once;

82 (D) Such insurer, center, society, corporation or other entity paid a
83 claim that should have been or was paid by a federal or state program;
84 or

85 (E) The health care provider received payment for such claim from a
86 different insurer, payor or administrator through coordination of
87 benefits or subrogation, or due to coverage under an automobile
88 insurance or workers' compensation policy. Such health care provider
89 shall have one year after the date of the cancellation, denial or return of
90 full or partial payment to resubmit an adjusted secondary payor claim
91 with such organization on a secondary payor basis, regardless of such
92 insurer's, center's, society's, corporation's or other entity's timely filing
93 requirements.

94 (2) (A) Such insurer, center, society, corporation or other entity shall
95 give at least thirty days' advance notice to a health care provider by
96 certified mail, return receipt requested, electronic mail to such electronic
97 mail address designated by such health care provider or facsimile, or
98 through a secure electronic health care provider portal or electronic
99 clearinghouse used for claims or remittance communications, of the
100 insurer's, center's, society's, corporation's or other entity's cancellation,
101 denial or demand for the return of full or partial payment pursuant to
102 subdivision (1) of this subsection.

103 (B) If such insurer, center, society, corporation or other entity
104 demands the return of full or partial payment from a health care
105 provider, the notice required under subparagraph (A) of this
106 subdivision shall disclose to the health care provider (i) the amount that
107 is demanded to be returned, (ii) the claim that is the subject of such
108 demand, and (iii) the basis on which such return is being demanded.

109 (C) Not later than thirty days after the receipt of the notice required
 110 under subparagraph (A) of this subdivision, a health care provider may
 111 appeal such cancellation, denial or demand in accordance with the
 112 procedures provided by such insurer, center, society, corporation or
 113 other entity, which shall include, but need not be limited to, an
 114 electronic appeal process. If any such insurer, center, society,
 115 corporation or other entity fails to notify the health care provider of such
 116 insurer's, center's, society's, corporation's or other entity's determination
 117 of such appeal not later than thirty business days after receipt of such
 118 appeal from such health care provider, such appeal shall be construed
 119 in favor of such health care provider. Any demand for the return of full
 120 or partial payment shall be stayed during the pendency of such appeal.

121 (D) If there is no appeal or an appeal is denied, such health care
 122 provider may resubmit an adjusted claim, if applicable, to such insurer,
 123 center, society, corporation or other entity, not later than thirty days
 124 after the receipt of the notice required under subparagraph (A) of this
 125 subdivision or the denial of the appeal, whichever is applicable, except
 126 that if a return of payment was demanded pursuant to subparagraph
 127 (C) of subdivision (1) of this subsection, such claim shall not be
 128 resubmitted.

129 (E) A health care provider shall have one year after the date of the
 130 written notice set forth in subparagraph (A) of this subdivision to
 131 identify any other appropriate insurance coverage applicable on the
 132 date of service and to file a claim with such insurer, center, society,
 133 corporation or other issuing entity, regardless of such insurer's, center's,
 134 society's, corporation's or other issuing entity's timely filing
 135 requirements.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2027	38a-479b(c)
Sec. 2	January 1, 2027	New section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill has no fiscal impact to the state or municipalities. It makes changes to laws regarding claim payments and appeals between health insurers and health care providers. These changes do not impact state and municipal health care plans.

House "A" alters the original bill by making technical changes regarding repayment from health care providers to insurers due to administrative or eligibility errors resulting in no fiscal impact.

OLR Bill Analysis**sHB 5377 (as amended by House "A")******AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS AND SITE OF SERVICE BILLING REQUIREMENTS.*****SUMMARY**

This bill makes changes to laws regarding claim payments and appeals between health care providers (for example, physicians) and (1) contracting health organizations (managed care organizations and preferred provider networks) or (2) health insurance carriers (for example, insurance companies, hospital or medical service corporations, HMOs, or fraternal benefit societies).

For contracting health organizations' provider claim payment and appeals processes, the bill:

1. reduces, from 18 months to 12 months, the time period after receiving a clean (complete and error-free) claim during which a contracting health organization may generally cancel, deny, or demand full or partial return of payment from a health care provider due to an administrative or eligibility error;
2. allows organizations to use a secure electronic provider portal or electronic clearinghouse used for claims or remittance communications to give providers the 30-day minimum advance notice of a payment cancellation, denial, or demand, notice required by law;
3. specifies that if the above notice is sent by (a) mail, it must be sent by certified mail, return receipt requested, or (b) email, it must be sent to an email address the provider designates; and

4. requires the organization to notify the provider of its appeal determination within 30 business days after receiving the provider's appeal, otherwise the appeal must be construed in the provider's favor.

It also applies the provider claim payment and appeals provisions that apply to contracting health organizations, under existing law and the bill, to health insurance carriers that deliver, issue, renew, amend, or continue certain individual or group health insurance policies in Connecticut on or after January 1, 2027.

*House Amendment "A" (1) reduces, from 15 months to 12 months, the time limit in the underlying bill by which a health organization may take an adverse action on a full or partial payment of an authorized service; (2) increases, from 12 business days to 30 business days, the time limit in the underlying bill by which health organizations must notify providers of an appeal determination; (3) deletes the provision in the underlying bill on off-site facility billing requirements; and (4) applies the claim payment and appeals provisions that apply to contracting health organizations under existing law and the bill to certain health insurance carriers.

EFFECTIVE DATE: January 1, 2027, and applicable to individual and group health insurance policies delivered, issued for delivery, renewed, amended, or continued in Connecticut on or after that date.

PROVIDER CLAIM PAYMENT AND APPEALS PROCESSES

Contracting Health Organizations

Time Limit. Current law generally prohibits a contracting health organization from canceling, denying, or demanding the return of full or partial payment for an authorized covered service, due to administrative or eligibility error, more than 18 months after receiving the clean claim. The bill reduces this to 12 months after receiving the clean claim.

Under existing law, unchanged by the bill, the time limit does not

apply if the:

1. organization (a) has a documented basis to believe that the provider fraudulently submitted the claim, (b) already paid the provider for the claim, or (c) paid a claim that should have been or was paid by a federal or state program; or
2. provider (a) did not bill the claim appropriately based on documentation or evidence of what medical service was provided or (b) received payment from a different insurer, payor, or administrator through coordination of benefits, subrogation, or coverage under an automobile insurance or workers' compensation policy.

Advance Notice. Under existing law, an organization must give a provider at least 30 days' advance notice of a payment cancellation, denial, or return demand by mail, email, or fax. The bill specifies that if the notice is sent by mail, it must be sent by certified mail, return receipt requested; and if it is sent by email, it must be sent to the provider's designated email. The bill also gives organizations the option of providing this notice through a secure electronic provider portal or electronic clearinghouse used for claims or remittance communications.

Appeal. By law, a provider may appeal, in accordance with the organization's procedures, a payment cancellation, denial, or return demand within 30 days after receiving notice of it. Current law does not specify a mode for the appeal process. The bill explicitly requires organizations to have an electronic appeal process available to providers but allows them to have additional means to appeal available.

Further, the bill requires the organization to notify the provider of the appeal determination within 30 days after receiving the appeal. Under the bill, if the organization fails to do so, then the appeal must be construed in the provider's favor.

Existing law, unchanged by the bill, requires a payment return demand to be stayed (postponed) during the appeal.

Health Insurance Carriers

The bill applies the provider claim payment and appeals provisions that apply to contracting health organizations, under existing law and the bill (as described above), to health insurance carriers that deliver, issue, renew, amend, or continue individual or group health insurance policies in Connecticut on or after January 1, 2027, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. (Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

BACKGROUND

Related Bill

SB 341 (File 209), favorably reported by the Insurance and Real Estate Committee, has similar provisions on (1) provider payment, cancellation, denial, and return and (2) the appeal determination notice.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 13 Nay 0 (03/12/2026)