Cost Analysis for Connecticut SB 10 (2025): Utilization Management and Additional Provisions

April 2025

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Havarti Risk is focused on earning our client's trust through excellence in quantifying, managing, and transferring health cost of care risk. Founded by a group of former health insurance Chief Actuaries, Havarti is highly regarded by healthcare start-up founders, reinsurers, health plans, and venture capital firms. Havarti's team of senior advisors leverages extensive actuarial experience to assist clients in demonstrating value, exploring risk-based pricing alternatives, and delivering critical business insights.

Scope and Objective

Havarti Risk (Havarti) was retained by the Connecticut Association of Health Plans to conduct an independent analysis concerning the potential cost implications (for medical and pharmacy benefits) of Connecticut Senate Bill (SB) 10, as referred to the Committee on Insurance and Real Estate on February 26, 2025. The purpose of this report is to communicate the findings of an analysis with respect to health benefits in Connecticut for each impacted market segment with respect to health plan customers for use by the Connecticut Association of Health Plans. It should be noted that any usage of this report beyond its intended purposes may be inappropriate.

The scope of the referenced bill is broader than considered in this report and a comprehensive analysis would include the impacts associated with administrative burden on providers and insurers, as well as other impacts such as arbitration and litigation. No impacts beyond the medical and pharmacy cost are included in this analysis.

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Executive Summary

Connecticut SB 10, as referred to the Committee on Insurance and Real Estate on February 26, 2025, proposes several new requirements for health care coverage provided by insurers and employer plan administrators (health plans). Havarti focused primarily on key provisions that would impact the cost of health benefits, specifically in the areas of utilization management (utilization reviews and step therapy).

To estimate the impact of the proposed legislation, Havarti developed a model using a rigorous approach that aims to mirror approaches that would be taken by health plan actuaries pricing health benefits in Connecticut if the legislation were to become law.

The table below shows our estimates for how SB 10 would impact the cost of health benefits in Connecticut within various market segments as compared to costs under current law (once fully implemented with the impacts reaching a steady state).

	At Full Implementation			
Connecticut Market Segment	**Annual Impact**	**Percentage Impact**	**Family of Four Per Year Impact**	**10-Year Impact**
Fully Insured (Indv & Employers)	$697 to $907 million	7.0% to 9.2%	$2,835 to $3,685	$7.6 to $11.6 billion
Self Funded Employers	$554 to $743 million	5.8% to 7.8%	$2,337 to $3,132	$6.3 to $9.7 billion
State Employee Health Plan	$43 to $64 million	3.0% to 4.5%	$1,216 to $1,827	$0.6 to $0.9 billion

These impact estimates above include just the utilization review and step therapy provisions. We also analyzed provisions related to stop-loss requirements and site-neutral payments. As we explain later in the report, those provisions (among others) exhibit significant uncertainty, and we are thus not including them in the summary impact totals.

The ranges in this analysis reflect the significant uncertainty related to outcomes associated with SB 10. Not only would key details likely be defined by regulation, but there is also particular uncertainty with respect to how health plans would react to a legal presumption that requested services are medically-necessary. As explained in more detail below, some health plans may see the rebuttable presumption as an impossible legal standard to meet and cease a significant portion of utilization reviews, while others may continue to operate a substantial utilization management program.

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Background: Utilization Management

The individuals and entities purchasing health benefits—including families, employers, and government entities—expect health plans to use their recourses wisely. This expectation includes maximizing health outcomes, mitigating wasteful spending and ensuring the right care is provided at the right place at the right time. Health plans deploy many tools that aim to achieve these goals, including prior authorization, step therapy, and other forms of utilization reviews collectively referred to as "utilization management". Health plans apply utilization management to a subset of covered benefits, typically for services that are high-cost, experimental, have mixed evidence for efficacy that depend upon specific circumstances, and/or exhibit meaningful levels of waste or abuse.

Medical Necessity

When a health plan is conducting a utilization review (e.g., reviewing a prior authorization request from a treating physician), it is evaluating whether the requested item or service is (1) a covered benefit pursuant to the benefit contract, and (2) medically-necessary pursuant to the health plan's coverage guidelines, also called medical policy. Each health plan develops its own medical policy, which is derived from work published by medical specialty societies (e.g., the American Academy of Neurology), government agencies, research institutions, and other sources. Health plans often publish medical policy guidelines on their websites to show the citations and rationale for coverage decisions.

Under current practice, when a health plan is conducting a review for medical necessity, the burden is on the treating clinician to demonstrate that the requested service meets the criteria established by the health plan pursuant to its medical policy. In the example of a prior authorization, the typical process is initiated by the treating clinician when the treatment is scheduled. The treating clinician provides documentation to the health plan and the health plan renders a decision on whether the request is consistent with the plan's medical policy guidelines. For adverse coverage determinations, providers often work with the health plan to either provide additional documentation or determine an alternative path forward that would be covered. In addition, for unresolved adverse determinations, an appeal process exists that is governed by state or federal law, depending upon the coverage type.

While health plans view utilization management as an important tool to maximize healthcare outcomes and manage resources, providers cite a significant administrative burden, and federal and state governments have considered and enacted regulations governing the practice. For example, federal regulations going into effect in 2026 for prior authorization require health

plans to implement streamlined processes to ease provider burden and make decisions within specific timeframes.

Rebuttable Presumption

A rebuttable presumption (such as that considered in SB 10) is a legal principle where a fact is assumed to be true unless proven otherwise by the opposing party. In the context of SB 10, the burden of proof for medical necessity would be reversed as compared to current practice. Instead of the provider being required to provide documentation that a requested service meets clinical guidelines, the health plan would be required to demonstrate that the service is not medically-necessary.

Step Therapy

Step therapy is one tool used by health plans to manage resources that is governed by the plan's medical policy. Step therapy requires patients to try clinically proven, lower-risk drugs before obtaining reimbursement for more expensive/higher-risk drugs for the same condition. Generally, patients must demonstrate that the clinically proven, lower-risk medication is insufficiently effective before the plan will cover the more expensive/higher-risk medication.

Due to policymaker concerns related to consumer and provider abrasion, states have considered and enacted legislation regulating the practice. Existing law in Connecticut prohibits health plans from requiring individuals to try drugs for more than 30 days and prohibits health plans from requiring step therapy for certain conditions.

Background: Site-Neutral Payments

Outpatient services can be provided at a range of provider facilities, including outpatient departments that are connected to a hospital, outpatient departments that may be owned by a hospital but located off campus, ambulatory surgery centers, and physician offices. Generally, health systems demand a higher reimbursement rate when outpatient services are performed in hospital-owned outpatient departments, even if the services are the same as those provided at physician offices. This payment differential has become more costly due to the recent trend of hospital systems purchasing physician practices. Once these practices are a part of the hospital system, the hospital secures the higher reimbursement rates resulting in higher out-of-pocket cost sharing for patients.

Because there is little or no evidence that the quality of care is higher for outpatient services in a hospital setting, private payers, policymakers, and regulators have evaluated ways to adopt

"site-neutral payment" policies that would reimburse providers the same rate for certain outpatient services irrespective of the site-of-service. Typically, policymakers are trying to achieve savings by requiring providers accept lower rates reflected at lower-cost sites-of-service.

Background: Stop-Loss Insurance and Employer Benefits

Federal and state law set standards employers must meet for health benefit contracts. Federal and state laws differentiate between (1) small employers with 50 or fewer employees purchasing state-regulated insurance, (2) large employers that purchase state regulated insurance, and (3) employers (typically large) that self-fund their own benefits and contract with a health plan to administer the benefits under ERISA.[1] To ease the ability for employers to offer employees/families consistent benefits across state lines, federal ERISA law includes a preemption clause that prohibits states from regulating that coverage.

Generally speaking, small employer insurance must cover "essential health benefits" (EHBs) defined under federal law as well as benefit mandates under state law, while large employer coverage (which is often richer coverage irrespective of government mandates) is not required to cover EHBs but are prohibited from establishing annual or lifetime dollar limits on EHBs that they do offer.

While employers that self-fund their own benefits are not purchasing traditional state-regulated insurance, many (particularly medium-sized employers) choose to purchase stop-loss insurance that pays for medical claims that exceed certain thresholds, either on an individual or aggregate level. Due to concerns that small employers can avoid some mandated benefits by self-funding coverage and then purchasing stop-loss coverage that pays for high medical claims with a low "attachment point", some states have considered or enacted regulation on stop-loss coverage that aims to inhibit smaller employers from joining the self-funded market instead of the state regulated, fully-insured, market.

[1]The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for employers that fund their own health plans (as an alternative to purchasing state-regulated insurance benefits). One goal of ERISA law is to allow multi-state employs to offer consistent benefits across state lines.

Legislation Analyzed: SB 10

Requirements

Connecticut SB 10, as referred to the Committee on Insurance and Real Estate on February 26, 2025, would establish new requirements related to health plan utilization management, benefits, provider payment, and rate filings. For the impact analysis, Havarti focused on the major quantifiable provisions that have some level of certainty and would impact the cost of health benefits for individuals and employers, which include the following:

- **Medical necessity determinations for utilization reviews:** Establishing a rebuttable presumption that services requested by a provider are medically-necessary; and
- **Step therapy under the drug benefit:** Reducing the maximum time period for step therapy from 30 days to 20 days and expanding the scope of conditions for which step therapy is prohibited.

The legislation also includes significant new requirements related to site-neutral payments, stop-loss coverage, rate filings, the use of artificial intelligence, and limitations for specific benefits. While we did not include those provisions in the summary impact analysis due to high levels of uncertainty related to outcomes, we include discussion towards the end of the report on these provisions and potential impacts.

Scope

Most of the provisions in SB 10 would apply to the fully-insured commercial market, including individual market coverage (e.g., Access Health CT) and small/large employers purchasing state-regulated, fully-insured coverage for employees and families. However, the provision related to stop-loss coverage aims to apply to self-funded employers that purchase stop-loss coverage regulated by the state.

Effective Date

If signed into law, some provisions would be effective October 1, 2025, while others would be effective January 1, 2026.

Interpretation and Implementation Challenges

While we address our analysis approach in the Methodology section below, we want to note that we see some interpretation challenges associated with SB 10 that could lead to inconsistent implementation across health plans. Challenges could include the following:

- **Uncertainty associated with rebuttable presumption legal standard for medical necessity**: Each health plan has its own compliance department with varying levels of tolerance for litigation risk. While SB 10 establishes a rebuttable presumption that requested services are medically-necessary, it is not clear how a health plan's medical guidelines would be interpreted by the courts. Additionally, in an environment where the health plan—which typically does not have the patient's full medical record—is the party that is required to rebut a recommendation, there is an information asymmetry that may not make this system workable.
- **Key details could be defined under regulations and/or guidance:** Due to the complexity of the legislation and the likelihood for health plans to take varying approaches, we expect regulations and/or guidance will be issued by the Department of Insurance that impacts how the legislation is implemented.

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Methodology and Approach

To estimate the impact of the proposed legislation, Havarti developed a model using a rigorous approach that aims to mirror approaches that would be taken by health plan actuaries pricing health benefits in Connecticut if the legislation were to become law. Such approaches would vary by health plan, but key elements would include the following, by provision:

- **Rebuttable presumption that services requested by providers are medically-necessary:**
  - Identifying claims that are not paid under current law but would be paid if the legislation became law (while subtracting-out the cost of replacement services);
  - Estimating additional costs associated with provider behavior changes when providers have knowledge that it is more difficult for health plans to challenge requested services on the basis of medical necessity;
- **Step therapy changes:** Identifying claims that are not paid under current law but would be paid if the legislation became law (while subtracting-out the cost of replacement drugs);
- **Site neutral billing:** Identifying the possible implementation approaches with provider contracting teams and calculating a range of potential outcomes; and
- **Stop-loss provisions (including employer mandated benefits):** Evaluating risk pool changes and the additional cost of state-mandated benefits not currently included in self-funded employer contracts.

Data Sources

The Connecticut Association of Health Plans facilitated data submission for multiple health plans operating in Connecticut with data reflecting approximately 2 million covered individuals.

Our analysis focused on health plan data and analyses that include the following elements:

- Enrollment totals;
- Prior authorization decisions and dollars saved after accounting for replacement services;
- Estimates for provider behavior changes with reduced levels of prior authorization; and
- Step therapy and prior authorization savings by drug class.

We worked with the health plans to ensure data and analyses provided to Havarti did not include any personally-identifiable information. While we did not audit the data, we conducted checks on the data and analyses for completeness and reasonableness. Throughout our analysis, we used our professional judgement to apply reasonable adjustments to fit the data into our model.

Upon completion of the analysis, results were extrapolated to capture the impact to the full Connecticut health insurance market based on Kaiser Family Foundation information about the total number of individuals enrolled for each product line.[2]

Rebuttable Presumption that Services Requested by Providers are Medically-Necessary

Shifting the burden of demonstrating whether or not a service is medically-necessary from the provider to the health plan would disrupt a longstanding and established utilization review process. As a result of the increase in legal risk and operational challenges for health plans described above, we expect additional claims would be paid, as compared to current law.

To estimate the impact SB 10 would have on costs for the health plan medical benefit, we developed estimates for two main dynamics: (1) claims that would be denied under current law but paid under SB 10 (while subtracting the cost of replacement services), and (2) provider service pattern changes that would be likely to occur if providers knew they were not subject to prior authorization reviews (known as the "sentinel effect"). The sentinel effect is a common factor used in economic analysis and refers to behavioral changes that occur when individuals are aware they are being observed and measured.

To determine the cost of additional claims that would be paid under SB 10, we relied on the health plan provided data noted above and conducted interviews to determine how health plans would consider implementing the legislation if it became law.

Given the challenges health plans would have conducting utilization reviews under a rebuttable presumption legal standard, we assume between 90% and 100% of prior authorization would be eliminated (encompassing both the medical benefit and the pharmacy benefit). For the 100% scenario, we calculated the total savings associated with prior authorizations, converted it to a per-member total, and extrapolated that cost across total membership. For the 90% scenario, we assumed any remaining prior authorization would focus on higher-cost services. We then calculated the total savings associated with the 90% reduction, converted it to a per-member total, and extrapolated that cost across total membership.

To determine additional costs associated with the sentinel effect noted above, we relied upon our health plan interviews and assume provider practice patterns would increase medical costs

[2] Kaiser Family Foundation. Health Insurance Coverage of the Total Population. Available at: https://www.kff.org/other/stateindicator/totalpopulation/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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in the range of 5% and 10% if they knew their actions would not get questioned by health plans. This range falls within the range published by the actuarial firm Milliman, which conducted a literature review when analyzing prior authorization legislation in Massachusetts and estimated the cost impact for the sentinel effect on a commercial population ranges from 4.1% to 16.7%.[3]

Step Therapy

To estimate the costs associated with the step therapy limitations in SB 10, analysis conducted by a HealthPlan was reviewed and verified by Havarti Risk. In that analysis, we concluded the cost increase to paid claims would be in the range of 1.9% to 2.5% of total pharmacy costs.

There is a broad range of interpretations regarding which drugs would have step therapy eliminated due to being considered life-threatening, disabling, or chronic. We took a middle-ground approach, assuming that many — but not all — drugs would be affected.

To determine additional costs associated with the sentinel effect for drug step therapy, like the medical rebuttable presumption, we assume provider practice patterns would increase prescription drug costs in the range of 5% and 10% if they knew their actions would not get questioned by health plans.

Distribution of Costs between Premium and Consumer Out-of-Pocket Costs

The cost estimates we developed would impact the cost for the medical and pharmacy benefit. The extent to which those costs are borne in the form of the premium (or the cost to the employer plan sponsor) versus the cost borne by the consumer in the form of an out-of-pocket cost (co-payments, etc.) would depend upon the benefit design. We did not attempt to distribute the cost impact by these two categories.

Assumptions for 10-Year Projections

To project impacts over a 10-year time horizon, we assumed medical costs would grow at 3% per year, and membership would remain constant (i.e., 0% growth). Adjusting these factors would significantly change the out-year projections.

[3] Milliman. Potential Impacts on Costs and Premiums Related to the Elimination of Prior Authorization Requirements in Massachusetts. November 2023. Available at: https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/11-29-23_MAHP-Prior-Authorization-Impact.pdf

Additional Potential Factors Not Included in Analysis

While our analysis focused on the major provisions and expected impacts, we did not account for how changes pursuant to SB 10 could impact health outcomes, either positively or negatively. We also did not evaluate potential changes for administrative costs for providers or insurers, although we would note that changes in administrative costs would likely exhibit a significantly smaller magnitude than the changes in the cost of medical benefits.

Results for Provisions Included in Impact Analysis

The following are the estimates we developed for the cost impact of SB 10 pursuant to the methodology noted above for the two provisions included in the impact analysis: (1) establishing a rebuttable presumption that services are medically-necessary, and (2) additional step therapy requirements. For additional provisions analyzed, see discussions in the sections that follow.

	At Full Implementation			
Connecticut Market Segment	**Annual Impact**	**Percentage Impact**	**Family of Four Per Year Impact**	**10-Year Impact**
Burden of Proof - Medical Necessity				
Fully Insured (Indv & Employers)	$656 to $841 million	6.6% to 8.5%	$2,668 to $3,418	$7.1 to $10.9 billion
Self Funded Employers	$504 to $662 million	5.3% to 6.9%	$2,124 to $2,792	$5.7 to $8.7 billion
State Employee Health Plan	$35 to $52 million	2.5% to 3.7%	$1,003 to $1,486	$0.5 to $0.8 billion
Step Therapy				
Fully Insured (Indv & Employers)	$41 to $66 million	0.4% to 0.7%	$167 to $267	$505 to $772 million
Self Funded Employers	$50 to $80 million	0.5% to 0.8%	$212 to $340	$635 to $978 million
State Employee Health Plan	$7 to $12 million	0.5% to 0.8%	$212 to $340	$109 to $165 million

As shown above, the estimated impacts are as follows, as compared to costs under current law:

Rebuttable Presumption that Services are Medically-Necessary

- **Fully Insured Individuals, Families, and Employers:** Individuals, families, and employers purchasing state-regulated insurance (including exchange coverage) would face premiums that are 6.6 percent to 8.5 percent higher, which equates to $2,668 to $3,418 per family of

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four per year. The aggregate increase for the market segment would be $656 to $841 million per year, or $7.1 billion to $10.9 billion over 10 years.

- **Employers self-funding health benefits:** Employers self-funding health benefits for employees and families in Connecticut (ERISA plans) would face premiums that are 5.3 percent to 6.9 percent higher, which equates to $2,124 to $2,792 per family of four per year. The aggregate increase for the market segment would be $504 to $662 million per year, or $5.7 billion to $8.7 billion over 10 years.
- **State employee health plan:** The State Employee Health Plan would face premiums that are 2.5 percent to 3.7 percent higher, which equates to $1,003 to $1,486 per family of four per year. The aggregate increase for the market segment would be $35 to $52 million per year, or $0.5 billion to $0.8 billion over 10 years.

Additional Step Therapy Requirements

- **Fully Insured Individuals, Families, and Employers:** Individuals, families, and employers purchasing state-regulated insurance (including exchange coverage) would face premiums that are 0.4 percent to 0.7 percent higher, which equates to $167 to $267 per family of four per year. The aggregate increase for the market segment would be $41 to $66 million per year, or $505 million to $772 million over 10 years.
- **Employers self-funding health benefits:** Employers self-funding health benefits for employees and families in Connecticut (ERISA plans) would face premiums that are 0.5 percent to 0.8 percent higher, which equates to $212 to $340 per family of four per year. The aggregate increase for the market segment would be $50 to $80 million per year, or $635 million to $978 million over 10 years.
- **State employee health plan:** The State Employee Health Plan would face premiums that are 0.5 percent to 0.8 percent higher, which equates to $212 to $340 per family of four per year. The aggregate increase for the market segment would be $7 to $12 million per year, or $109 million to $165 million over 10 years.

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Results for Provisions Excluded from Impact Analysis

We also analyzed and quantified the following provision but did not include it in the impact totals due to high levels of uncertainty.

Site-Neutral Payment

SB 10 would require health plans to use equal reimbursement rates for each contracted provider in the same geographic region for certain outpatient services—irrespective of site-of-service.

Unlike Medicare site-neutral legislation at the federal level that would mandate providers accept the lower rates reflected for physician offices, SB 10 is silent on how the site-neutral rate would be set. Thus, our analysis evaluated the full array of potential outcomes, with the maximum and minimum rate paid for each service that is in-scope of the legislation. The maximum price paid was used to determine the maximum rate impact, and the minimum price paid was used to determine the minimum rate impact. Given the extreme range produced by the full range of potential outcomes, a moderate rate impact was determined by assuming all claims would be paid at the market average price for office-based settings.

	Site-Neutral Billing		
Connecticut Market Segment	**Annual Impact at full implementation**		
	Low Impact	Moderate Impact	High Impact
Fully Insured (Individuals & Employers)	($156) million	$2 million	$1.8 billion
Self Funded Employers	($199) million	($33) million	$1.8 billion
State Employee Health Plan	($33) million	($4) million	$326 million

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Additional Provisions and Potential Impacts

The following are additional provisions in SB 10 that were not included in sections above, either due to uncertainty or because a likely low level of impact to benefit costs.

Stop-Loss Provisions (Including Employer Mandated Benefits)

To determine the cost associated with the stop-loss provisions, we attempted to evaluate health plan data showing the difference between the per member per month costs for self-funded employers in Connecticut and compared that to the cost of fully-insured employers that are subject to mandated benefits under existing law. Because the large difference is due to several factors, including mandated benefits and risk pool differences, we were not able to isolate what we believe would be the major impact of SB 10 for this provision: requiring state-mandated benefits be added to self-funded employers purchasing state-regulated stop-loss coverage.

Additionally, we are unclear to the extent to which self-funded employers would continue to purchase the Connecticut-regulated stop-loss coverage that would trigger the benefit requirement. Self-funded employers may find other ways to protect themselves from high claims costs.

Due to the complexity of this provision and the time constraint of this report, we are not publishing an estimated cost impact, although it would likely be a significant increase in cost and cost uncertainty for self-funded employers and therefore the employees who purchase Connecticut-regulated stop-loss coverage. Given additional time and data, a cost impact could be estimated.

Requirement that Rate Filings be “Affordable”

SB 10 would require rate filings for health insurance be “affordable”. It would require the Insurance Commissioner to determine whether a rate is inconsistent with the inflation-adjusted Connecticut Health Affordability Index or another metric determined by the Executive Branch.

The impact this provision would have on health insurance is highly uncertain. We note that an actuary preparing a rate filing cannot submit rates that are inadequate to cover the costs of providing health insurance. Whether the actuary believes the costs are affordable is not a permissible factor in the work of an actuary certifying rates according to Actuarial Standards of Practice. This conflict of interest could result in Actuaries refusing to sign off on the affordability of rates.

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The outcomes of this provision are unclear and could include insurers withdrawing from the market and reduce the likelihood of new insurers entering Connecticut. Ultimately, this could cause negative effects on the competitive landscape of the Connecticut health insurance market. Due to the uncertainty, we are not publishing an estimate for this provision.

Reporting/Enforcement of Mental Health Parity Laws

SB 10 would establish reporting requirements and require enforcement of mental health parity laws. Our experience and interviews with health plans indicate that health plans are already in compliance with state and federal mental health parity laws. While the provisions would increase administrative costs and create some uncertainty if levels of compliance become disputed by the regulator, due to the unknown levels of cost, we do not publish an estimate for this provision.

Prohibition on the Use of AI for Adverse Determinations

SB 10 would prohibit health plans from using artificial intelligence for adverse determinations in the context of utilization reviews. Our experience indicates health plans already have systems in place where human clinicians review adverse determinations. Therefore, we do not publish an estimate for this provision.

However, AI used properly has the potential to be a cost reducing tool that decreases the amount of administrative cost and time needed to conduct prior authorization. Removal of this tool could have a negative impact on the Connecticut health insurance market.

Prohibition on Certain Limits for Anesthesia and Ancillary Services

SB 10 would prohibit health plans from placing “arbitrary limitations” on anesthesia services and medically-necessary ancillary services. Our understanding is that this provision was introduced in response to a health plan’s policy that was withdrawn and is no longer in use. Because we are not aware of situations where this provision would change existing practice, we do not publish an estimate for this provision.

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Disclosure and Reliance

For this work, Havarti has relied upon data provided by health plans operating in Connecticut. The data has been reviewed according to ASOP 23 for reasonableness and suitability for the intended purpose and has been deemed to be sufficient to support this report. Havarti has not audited the data.

This report is intended to provide a range of potential financial impacts due to the legislation being considered in Indian SB 10, as introduced in 2025. This report is provided to Insurance Institute of Connecticut, who has engaged Havarti to complete this analysis in order to communicate the impacts of the proposed legislation. Other uses of the report are not intended.

Numerous assumptions were made to complete the report to estimate future impacts. Publicly-available research and studies were used to help inform these assumptions, but uncertainty exists in the assumptions used and actual results may differ materially from the estimates provided.

The scope of the referenced bills is broader than considered in this report and a comprehensive analysis would include the impacts associated with additional administrative burden on providers and insurers, as well as other impacts such as litigation.

It is also worth noting that this report was developed under a compressed timeline. Additional time and resources would likely have resulted in a more thorough analysis. Business and economic circumstances are dynamic and may impact this analysis, and the assumptions and estimates may not be valid after a period of time.

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