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Regulatory Updates July 2026

CMS-2454-IFC MEDICAID COMMUNITY ENGAGEMENT REQUIREMENT (PASSED)

- Effective 1/1/27
- New statutory requirement for certain adults in Medicaid to meet an 80 hours per month work requirement as a condition of eligibility.
- Impacts non-pregnant adults between 19 and 64 who are not entitled to or enrolled in Medicare and are eligible for or enrolled in the Medicaid adult group or section 1115 exception
- States must: identify impacted individuals, verify applicable individuals are meeting the requirement at application and renewal, provide outreach to affected populations, take steps to combat noncompliance, submit date to CMS to support program monitoring

CMS-2454-IFC MEDICAID COMMUNITY ENGAGEMENT REQUIREMENT (PASSED)

- Adults can meet the requirement if they:
  - Work, complete community service, or participate in a work program for not less than 80 hours;
  - Enroll in an educational program at least half-time;
  - Complete a combination of the activities described above for at least 80 hours; or
  - Have monthly income that is not less than the federal minimum wage multiplied by 80 hours.
- Exempt individuals: former foster care youth, Native Americans and Alaska Natives, caretakers of dependent child 13 years or younger or a disabled individual, veterans with total disability rating, medically frail individuals, meet TANF work requirements, member receiving SNAP benefits and not exempt from SNAP work requirements, pregnant or postpartum individuals, etc.
- Short-term hardship exceptions can allow individuals to be considered as meeting the work requirement (e.g. inpatient hospital treatment, emergency or disaster declaration, etc.)

LA SB 465: RECOUPMENT (PASSED, COMMERCIAL)

- Effective 1/1/27
- Markets: Commercial
- Dental recoupment (new):
  - A dental service contractor shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim for dental services rendered in good faith and pursuant to the benefit plan for any reason after 18 months from the date the initial claim was paid.
- Health insurance claims recoupment:
  - A health insurance issuer shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim for services rendered in good faith and pursuant to the benefit plan for any reason after the expiration of 12 months (used to be 18) from the date the initial claim was paid.

LA SB 465: RECOUPMENT (PASSED, COMMERCIAL)

- Nonelectronic claims:
  - Any nonelectronic claim by a healthcare provider submitted within the period of time set by the insurer for the timely filing of claim or resubmitted because the original claim was not accepted or a clean claim shall be paid, denied, or pended not more than 30 calendar days (used to be 45) from the date upon which a nonelectronic clean claim is received by the issuer.
  - Any nonelectronic claim by a healthcare provider for the provision of services that have prior authorization by the health insurance issuer shall be paid, denied, or pended not more than 10 calendar days (used to be 60) from the date upon which the claim is received by the issuer, unless it is not payable under the terms of the insurance contract.
  - Any other nonelectronic claim shall be paid, denied, or pended not more than 45 days from the date the claim was received. (not changed)
  - The issuer shall either provide written notice to the provider within 2 business days that a claim is pended or allow the provider internet access to such info. (new)

LA SB 465: RECOUPMENT (PASSED, COMMERCIAL)

- Electronic claims:
  - Any electronic claim for healthcare services that have prior authorization by the health insurance issuer shall be paid, denied, or pended not more than 10 calendar days (used to be 25) from the date upon which the claim is received by the issuer, unless it is not payable under the terms of the insurance contract.
  - Any electronic claim for healthcare services that do not have prior authorization by the health insurance issuer shall be paid, denied, or pended not more than 25 calendar days from the day upon which the claim is received, unless not payable under the contract. (new)
  - The issuer shall either provide written notice to the provider within 2 business days that a claim is pended or allow the provider internet access to such info. (new)

CO HB 1139: AI (PASSED, COMMERCIAL)

- Effective 1/1/27
- A carrier that uses AI for the purpose of utilization review shall ensure that the AI system bases its determination on the following:
    - The AI system bases its determination on the following:
    - An individual's medical or other clinical history
    - Individual clinical circumstances presented by the provider
    - Other relevant clinical information in the individual's record
    - The AI system does not base its decisions solely on group data without reference to individual data
    - The system is not used in any way that is discriminatory
    - The system is fairly and equitably applied
    - The system produces and retains documentation, audit logs, and model-governance records
    - The system's performance, use, and outcomes are periodically reviewed to maximize accuracy
    - An individual's health data is not used beyond its intended or stated purpose
    - The system's criteria and guidelines comply with state/federal law

CO HB 1139: AI (PASSED, COMMERCIAL)

- A carrier using AI for UR purposes shall provide written disclosures to the Division, Dept of Human Services, or Dept of Health Care Policy that identify:
  - The UR functions for which the AI will be used
  - The points in the UR process when the system is used
  - The human oversight process, including the qualifications of the reviewer and whether a human must approve an adverse determination
  - The process for maintaining sufficient audit information
- An AI system may be used to assist with UR
- A carrier's denial of coverage based in whole or in part on medical necessity shall not be issued solely on the output on an AI system without human review and approval by a qualified individual

VIRTUAL CREDIT CARD BILLS

- RI SB 3156: Died
- IL HB 4464: Passed 6/26/26, Effective 1/1/27
  - Commercial
  - No insurer shall require a dental provider to only accept payment from a credit card or EFT or to incur a fee to access and obtain payment/reimbursement
  - Any insurer may initiate or change payment methodology to a dental care provider using EFT payments, including VCC payments, if:
  - The provider is notified of any fees
  - The insurer advises the provider of the available payment methods and instructions on selection; and
  - The provider gives their express acceptance of the credit card or electronic funds transfer payment method
    - Express acceptance may be given by an electronic or digital signature, including checking a box indicating affirmative consent
  - Payment method remains until changed or a new contract is executed

OH SB 162: RECOUPMENT (LIKELY TO PASS, COMMERCIAL)

- Sent to Governor 7/1/26
- A payment made by a third-party payer to a provider shall be considered final **one year** after payment is made (after that date, not subject to adjustment except in the case of fraud)
- In order to recover payment, a third-party payer shall inform the provider of its determination of overpayment, give the provider an opportunity to appeal, and shall not charge for the appeal
- If the provider fails to respond to notice within 60 days, or their appeal is denied, the third-party payer may initiate recovery
- The notice shall specify all of the following:
    - The full name of the beneficiary
    - The date/dates of service
    - Amount of overpayment
    - The claim number or other pertinent numbers
    - A detailed explanation of basis for the overpayment determination
    - The method in which payment was made, the date of payment, and the check number if applicable
    - That the provide may appeal if they respond within 60 days
    - The method by which recovery would be made
- The notice shall be in writing, but can be given electronically if the payer and provider agree upon an established electronic notification system