SKYGEN REGULATORY UPDATES

SEPTEMBER 2026

PASSED: CT HB 5377 (COMMERCIAL)

- **Provider Payments/Recoupment**
- Effective 1/1/27
- Reduces recoupment period from 18 months to 12 months after the date of receipt of a clean claim (with exceptions for fraud, double payment, inappropriate billing)
- A health organization shall give at least 30 calendar days notice by certified mail, return receipt requested, electronic mail to a designated email address, facsimile, or through a secure electronic portal, of the recoupment initiation
- The notice shall disclose the amount to be returned, the claim in question, and the basis on which the return is being requested

PASSED: CT HB 5377 CONT. (COMMERCIAL)

- The provider may appeal within 30 days of receipt of notice, and an electronic appeals process shall be available
- If the organization fails to notify the provider of their appeal determination within 30 business days, the appeal shall be decided in favor of the provider
- If the provider does not appeal, or the appeal is denied, the provider may resubmit an adjusted claim to the organization within 30 days of receipt of the initial notice or of the appeal denial
- A provider has 1 year after the date of notice to identify any other appropriate insurance coverage applicable on the date of service and to file a claim with such entity

PASSED VISION BILLS: LA SB 404 AND IL SB 3707

- Do we have vision business in LA and/or IL?
- These bill deal with vision provider contracts, including fee schedule requirements, recoupment timelines, marketing requirements, etc.

LIKELY TO PASS: CA AB 280 (MEDICAID, COMMERCIAL)

- **Provider Directories**
- Presented to Governor 9/4/26
- Effective 7/1/27 if passed
- Requires the Department of Managed Health Care to develop uniform provider directory standards
- Requires an insurer to provider coverage for all covered benefits provided to an insured who reasonable relied on inaccurate information contained in the provider directory
- Requires the insurer to ensure the accuracy of a request to add back a provider who was removed from the directory and approved the request, if accurate, within 10 business days

LIKELY TO PASS: CA SB 1049 (MEDICAID, COMMERCIAL)

- **Claims Reimbursement**
- Presented to Governor 8/28/26
- Effective 1/1/27 if passed
- Allows a claimant 90 calendar days to submit a corrected claim after a denial or notice of overpayment based on a defect that may be remedied by submitting a corrected claim
- Prohibits an insurer from denying a corrected claim on the grounds that the claim was not submitted within another applicable filing deadline

LIKELY TO PASS: CA AB 539 (MEDICAID, COMMERCIAL)

- **Prior Authorization Duration**
- Presented to Governor 9/3/26
- Effective 1/1/27 if passed
- Requires an approved prior authorization for a service requested by an in-network provider to remain valid for at least 1 year from the date of approval, or the period requested by the provider if less than 1 year

LIKELY TO PASS: CA AB 2756 (MEDICAID)

- **Medi-Cal Vision Performance Measures (awareness only)**
- Presented to Governor 8/28/26
- Effective 1/1/27 if passed, phased deadlines for Dept of 1/1/28, 1/1/29
- Dept, by 1/1/28, would have to establish performance measures to ensure that vision services under Medi-Cal meet quality/access criteria
- Dept would be required to report on each performance measure and post measures and data to the department's website
- Reporting requirements in 2028 or 2029, we will look out for these

WATCH: NH NETWORK ADEQUACY PROPOSED RULE (COMMERCIAL)

- **Dental Benefit Plan Network Adequacy**
- Proposed 7/21/26, public comment period ended 8/27/26
- Applies when insurers are offering coverage to a NH resident
- **Basic coverage.** Every health benefit plan shall:
  - Maintain a sufficient provider network to ensure all covered services are accessible without unreasonable delay in each county in which the carrier has a health benefit plan
  - Ensure compliance with time/distance standards for network adequacy in the CMS 2023 Letter to Insurers in the Federally-facilitated exchanges
  - If at any time a carrier does not have adequate participating providers, the carrier shall cover services provided by a non-participating provider at no greater cost

WATCH: NH NETWORK ADEQUACY PROPOSED RULE (COMMERCIAL)

- **Filing Requirements**
  - Every carrier shall, at the time its plans and rates for the upcoming play year are filed for review, *create* a network provider listing for each of the plans that the carrier offers in NH using a template provided by the commissioner
  - If the carrier is unable to verify compliance with the network adequacy requirements, the carrier shall:
    - Submit explanation of the reason, the steps taken to recruit additional providers, whether the services are available through telehealth, and any other mitigating measures
    - Pay a NPP to provide impacted services at no extra cost
    - Ensure the policy includes notice to the covered person that the impacted services are available from a NPP at no extra cost

WATCH: NH NETWORK ADEQUACY PROPOSED RULE (COMMERCIAL)

- **Appointment Wait Time Standards**
  - Initial appointment within the following standards:
    - 48 hours for urgent care
    - 10 days for behavioral health care
    - 15 days for routine primary care
    - 30 days for specialty care
  - Telehealth cannot be used to meet wait time standards where use of telehealth would be inappropriate for the care sought of the patient is not capable/does not consent to telehealth
  - Carriers shall establish an access point where covered persons can receive scheduling assistance
  - Assistance requests shall be addressed within 3 business days

WATCH: NH NETWORK ADEQUACY PROPOSED RULE (COMMERCIAL)

- **Choice of and access to Specialty Care Providers**
  - Carriers shall establish policies through which a member with a condition requiring care from a specialist may obtain a referral to a specialist
  - The carrier shall not require an additional referral to the same specialist or group practice within 6 months when the patient is expected by the referring provider to specify an individual practitioner in the referral
  - Carriers shall ensure that covered persons may obtain a referral to a provider outside of the carrier's network when the carrier does not have a provider with appropriate training and experience for the covered person's particular health needs
  - When a carrier has approved a referral to a NPP for specialty care, the carrier shall cover all covered services provided by the NPP reasonably related to the specialty care unless the carrier provides at least 14 days prior written notice to the covered person specifying that the services will not be covered when performed by the NPP and provides a list of providers where the covered person can receive the services identified

WATCH: PA HB 2722 (COMMERCIAL)

- **Dental insurance transparency and electronic notice**
- Referred to insurance 7/31/26
- Effective one year from passage
- **Portal**
  - Every dental insurer shall maintain a secure electronic provider portal that provides access to complete and accurate benefit information for covered patients, updated daily
  - All information on the portal shall be reflective of statements, agreements, and treatment history for at least the last three years, including:
    - Procedures billed, dates of service, benefits payments, denials, frequency of utilization, remaining limitations and eligibility data

WATCH: PA HB 2722 (COMMERCIAL)

- Information shall be available without additional contact with the insurer or a representative beyond the provider platform
- Any statement of a benefit qualified for or provided by the insurer, verbally, electronically, or in writing, shall be binding for the purpose of claim adjudication and benefit determination, and any statement regarding a dollar amount shall be binding, with exceptions for fraud, material misrepresentation, or eligibility termination occurring after the info was provided
- **Record Retention**
  - Dental insurers shall maintain recordings/transcripts of benefit breakdown verification communication for a minimum of three years
  - Upon request, copies shall be made available to providers and authorized staff

SMES FOR FUTURE REGULATORY PROJECTS

- Trying out a new template for regulatory compliance implementation
- Need SMEs to designate to be assigned to the different department categories
- These SMEs don't necessarily need to always be in charge of implementation in their departments, but will serve as a contact person