



Senate

General Assembly

File No. 447

February Session, 2026

Substitute Senate Bill No. 3

Senate, April 7, 2026

The Committee on Human Services reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE AFFORDABILITY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective July 1, 2026*) (a) There is established the
2 Connecticut Affordable Health Care Trust Fund. Said fund may contain
3 any moneys required or permitted by law to be deposited in the fund
4 and shall receive and hold all payments and deposits for contributions
5 intended for said fund, as well as gifts, bequests, endowments or
6 federal, state or local grants and any other funds from any public or
7 private source and all earnings until disbursed in accordance with the
8 provisions of this section.

9 (b) The amounts on deposit in said fund shall not constitute property
10 of the state and said fund shall not be construed to be a department,
11 institution or agency of the state. Amounts on deposit in said fund shall
12 not be commingled with state funds and the state shall have no claim to
13 or against, or any interest in, such deposits. Any contract entered into
14 by or any obligation of said fund shall not constitute a debt or obligation
15 of the state and the state shall have no obligation to any person on

16 account of said fund and all amounts obligated to be paid from said
17 fund shall be limited to amounts available for such obligation on deposit
18 in said fund. Said fund shall continue in existence as long as it holds any
19 deposits or has any obligations and until its existence is terminated by
20 law.

21 (c) Notwithstanding the provisions of sections 3-13 to 3-13h,
22 inclusive, of the general statutes, the Treasurer shall invest the amounts
23 on deposit in said fund in a manner reasonable and appropriate to
24 achieve the objectives of said fund, exercising the discretion and care of
25 a prudent person in similar circumstances with similar objectives. The
26 Treasurer shall give due consideration to rate of return, risk, term or
27 maturity, diversification of the total portfolio within said fund, liquidity,
28 the projected disbursements and expenditures and the expected
29 payments, deposits, contributions and gifts to be received. The
30 Treasurer shall not require said fund to invest directly in obligations of
31 the state or any political subdivision of the state or in any investment or
32 other endowment administered by the Treasurer. The assets of said
33 fund shall be continuously invested and reinvested in a manner
34 consistent with the objectives of said fund until expended in accordance
35 with the provisions of this section.

36 (d) The Treasurer, on behalf of said fund and for purposes of said
37 fund, may:

38 (1) Receive and invest moneys in said fund in any instruments,
39 obligations, securities or property in accordance with this section;

40 (2) Enter into one or more contractual agreements, including
41 contracts for legal, actuarial, accounting, custodial, advisory,
42 management, administrative, advertising, marketing and consulting
43 services for said fund and pay for such services from the assets of said
44 fund;

45 (3) Procure insurance in connection with said fund's property, assets,
46 activities or deposits to said fund;

47 (4) Apply for and accept gifts, grants or donations from public or
48 private sources to enable said fund to carry out its objectives;

49 (5) Adopt regulations in accordance with chapter 54 of the general
50 statutes for purposes of this section;

51 (6) Sue and be sued;

52 (7) Establish one or more accounts within said fund; and

53 (8) Take any other action necessary to carry out the purposes of this
54 section and incidental to the duties imposed on the Treasurer pursuant
55 to this section.

56 (e) Amounts on deposit in the Connecticut Affordable Health Care
57 Trust Fund, if any, shall be used to implement the Connecticut Option
58 affordable health care program established pursuant to section 4 of this
59 act.

60 (f) The Treasurer shall ensure that sufficient liquidity exists within
61 the fund to allow for expenditures in each fiscal year.

62 Sec. 2. Section 3-13c of the 2026 supplement to the general statutes is
63 repealed and the following is substituted in lieu thereof (*Effective July 1,*
64 *2026*):

65 As used in sections 3-13 to 3-13e, inclusive, and 3-31b, "trust funds"
66 includes the Connecticut Municipal Employees' Retirement Fund A, the
67 Connecticut Municipal Employees' Retirement Fund B, the Soldiers,
68 Sailors and Marines Fund, the Family and Medical Leave Insurance
69 Trust Fund, the State's Attorneys' Retirement Fund, the Teachers'
70 Annuity Fund, the Teachers' Pension Fund, the Teachers' Survivorship
71 and Dependency Fund, the School Fund, the State Employees
72 Retirement Fund, the Hospital Insurance Fund, the Policemen and
73 Firemen Survivor's Benefit Fund, any trust fund described in
74 subdivision (1) of subsection (b) of section 7-450 that is administered,
75 held or invested by the State Treasurer, the Connecticut Baby Bond
76 Trust, any Climate Change and Coastal Resiliency Reserve Fund created

77 pursuant to section 7-159d, the Early Childhood Education Endowment,
78 the Connecticut Affordable Health Care Trust Fund established
79 pursuant to section 1 of this act and all other trust funds administered,
80 held or invested by the State Treasurer.

81 Sec. 3. (*Effective July 1, 2026*) Notwithstanding the provisions of
82 sections 3 and 4 of special act 26-1, for the fiscal year ending June 30,
83 2027, the Secretary of the Office of Policy and Management shall transfer
84 two hundred million dollars from the Federal Cuts Response Fund,
85 established pursuant to section 1 of special act 26-1, to the Connecticut
86 Affordable Health Care Trust Fund established pursuant to section 1 of
87 this act.

88 Sec. 4. (NEW) (*Effective from passage*) (a) As used in this section and
89 section 7 of this act:

90 (1) "Access Health Connecticut" means the Internet web site
91 maintained by the Connecticut Health Insurance Exchange, established
92 pursuant to section 38a-1081 of the general statutes, through which
93 enrollees and prospective enrollees may obtain standardized
94 comparative information on and enroll in qualified health plans under
95 the Affordable Care Act;

96 (2) "Affordable Care Act" and "qualified health plan" have the same
97 meanings as provided in section 38a-1080 of the general statutes;

98 (3) "Affordable health plan" means a qualified health plan with
99 premiums that cost (A) not more than two per cent of household income
100 for persons with household income not exceeding two hundred per cent
101 of the federal poverty level, and (B) not more than eight and one-half
102 per cent of household income for persons with household income that
103 is four hundred per cent or more of the federal poverty level; and

104 (4) "Eligible enrollee" means a resident of the state who is eligible to
105 enroll in a qualified health plan on Access Health Connecticut and (A)
106 has household income not exceeding two hundred per cent of the
107 federal poverty level and is ineligible for the Covered Connecticut

108 program established pursuant to section 19a-754c of the general
109 statutes, or (B) has household income exceeding four hundred per cent
110 of the federal poverty level but not exceeding six hundred per cent of
111 the federal poverty level and is ineligible for federal premium subsidies
112 under the Affordable Care Act.

113 (b) There is established within the Office of Policy and Management
114 the Connecticut Option affordable health care program for the purpose
115 of creating affordable health insurance coverage. The Secretary of the
116 Office of Policy and Management, in consultation with the
117 Commissioner of Social Services, the Insurance Commissioner and the
118 chief executive officer of the Connecticut Health Insurance Exchange,
119 and subject to the recommendations of the working group established
120 pursuant to section 7 of this act, shall design and implement the
121 Connecticut Option program using moneys from the Connecticut
122 Affordable Health Care Trust Fund established pursuant to section 1 of
123 this act and any other state, federal or other funding sources available
124 to implement the provisions of this section.

125 (c) The Connecticut Option program shall include a state health care
126 premium subsidy to enable an eligible enrollee to obtain an affordable
127 health plan on Access Health Connecticut for the period beginning July
128 1, 2026, and ending December 31, 2027. The program may include, but
129 shall not be limited to:

130 (1) A buy-in option for a health plan that mirrors Medicaid;

131 (2) Other options for subsidies for eligible enrollees or other persons
132 for the purpose of purchasing an affordable health plan; and

133 (3) Additional affordable health care options for persons of all income
134 levels, promoted by means including, but not limited to, authorizing a
135 primary insurer to transfer portions of its risk portfolios to another
136 entity to limit maximum losses and stabilize financial performance.

137 (d) In designing and implementing the Connecticut Option program,
138 the Secretary of the Office of Policy and Management shall adopt the

139 Connecticut Option program recommended by the working group
140 established pursuant to section 7 of this act based on (1) analyses of
141 affordability, (2) projected impact on rates of uninsured persons, (3)
142 protection against adverse selection, (4) comprehensiveness of benefits,
143 and (5) impact on equitable access to health care and sustainability. The
144 secretary may:

145 (A) Solicit economic analysis of key policy options for affordable
146 health insurance, including, but not limited to, plans that mirror
147 Medicaid, qualified health plans or the state employee health plan,
148 which may include recommended policies to (i) promote cost
149 containment and network adequacy, and (ii) mitigate any impact on the
150 individual health insurance market;

151 (B) Accept gifts, grants and donations, which shall be deposited in
152 the Connecticut Affordable Health Care Trust Fund established
153 pursuant to section 1 of this act, and utilize any other available state or
154 federal funds; and

155 (C) Employ or enter into contracts with actuaries and other
156 professionals and enter into contracts with other state agencies, health
157 carriers or other qualified persons and entities as are necessary.

158 (e) Not later than January 1, 2027, every six months thereafter through
159 January 1, 2030, and annually thereafter, the Secretary of the Office of
160 Policy and Management shall submit a report, in accordance with the
161 provisions of section 11-4a of the general statutes, to the joint standing
162 committees of the General Assembly having cognizance of matters
163 relating to appropriations and the budgets of state agencies, human
164 services and insurance and real estate. The report shall contain a
165 narrative description of the operations, activities and finances of the
166 Connecticut Option program and any supporting documentation or
167 data.

168 Sec. 5. (NEW) (*Effective from passage*) (a) As used in this section and
169 section 6 of this act:

170 (1) "Affordable Care Act" has the same meaning as provided in
171 section 38a-1080 of the general statutes;

172 (2) "Eligible individual" means a state resident who (A) is under sixty-
173 five years of age, (B) has household income exceeding one hundred
174 thirty-three per cent of the federal poverty level but not exceeding two
175 hundred per cent of the federal poverty level, (C) is otherwise ineligible
176 for medical assistance programs established pursuant to chapter 319v of
177 the general statutes, and (D) is otherwise eligible to enroll in a qualified
178 health plan, as defined in section 38a-1080 of the general statutes, on
179 Access Health Connecticut, as defined in section 4 of this act; and

180 (3) "Basic health program" means a health care program authorized
181 under Section 1331 of the Affordable Care Act for eligible individuals
182 that is funded by federal payments to the state amounting to ninety-five
183 per cent of the health insurance premium tax credits and cost-sharing
184 reductions that would have otherwise been provided to, or on behalf of,
185 eligible individuals under the Affordable Care Act.

186 (b) On and after October 1, 2026, the Commissioner of Social Services,
187 in consultation with the Office of Policy and Management and based
188 upon the recommendations of the working group established pursuant
189 to section 7 of this act, shall seek any necessary approvals from the
190 federal government to establish a basic health program and take all
191 necessary actions to maximize federal funding.

192 (c) The commissioner shall, in accordance with the Affordable Care
193 Act, coordinate the administration of, and provision of benefits under,
194 the basic health program with the state medical assistance programs. To
195 the extent permissible under the Affordable Care Act, medical
196 assistance provided through the basic health program shall include the
197 benefits, limits on cost-sharing and other consumer safeguards that
198 apply to the state medical assistance programs.

199 (d) If the commissioner determines that the cost of medical assistance
200 provided to eligible individuals in the basic health program will exceed
201 federal subsidies, or if changes in federal law, regulations or the

202 administration of federal law or regulations affects funding, eligibility
203 for or administration of the program, the commissioner, in consultation
204 with the Office of Policy and Management, may develop a plan to
205 respond to such changes. To the extent that federal funds received under
206 the Affordable Care Act for the basic health program exceed the cost of
207 medical assistance that would otherwise be provided to eligible
208 individuals, the commissioner shall use such funds to reduce the
209 premiums and cost-sharing of, or provide additional benefits for,
210 eligible individuals in accordance with 42 USC 18051, as amended from
211 time to time.

212 (e) The Commissioner of Social Services shall forward any
213 application for federal approval of or changes to the basic health
214 program to the joint standing committees of the General Assembly
215 having cognizance of matters relating to appropriations and the budgets
216 of state agencies and human services and to the working group
217 established pursuant to section 7 of this act not later than thirty days
218 before seeking federal approval for the program.

219 (f) Not later than January 1, 2027, every six months thereafter through
220 January 1, 2030, and annually thereafter, the commissioner shall submit
221 a report, in accordance with the provisions of section 11-4a of the general
222 statutes, to the joint standing committees of the General Assembly
223 having cognizance of matters relating to appropriations and the budgets
224 of state agencies, human services and insurance and real estate. The
225 report shall contain a narrative description of the operations, activities
226 and finances of the basic health program for the immediately preceding
227 reporting period and any supporting documentation or data.

228 Sec. 6. (NEW) (*Effective July 1, 2026*) There is established an account
229 to be known as the "basic health program account", which shall be a
230 separate, nonlapsing account. The account shall contain any moneys
231 required by law to be deposited in the account. Moneys in the account
232 shall be expended by the Department of Social Services solely for the
233 purposes of operating a basic health program in accordance with the
234 Affordable Care Act.

235 Sec. 7. (NEW) (*Effective from passage*) (a) The Secretary of the Office of
236 Policy and Management shall establish a working group to oversee the
237 design of the Connecticut Option program established pursuant to
238 section 4 of this act and the basic health program established pursuant
239 to sections 5 and 6 of this act.

240 (b) The working group shall consist of:

241 (1) The Connecticut Healthcare Advocate, or the advocate's designee;

242 (2) The Insurance Commissioner, or the commissioner's designee;

243 (3) The Commissioner of Social Services, or the commissioner's
244 designee;

245 (4) The executive director of the Commission on Racial Equity in
246 Public Health, or the executive director's designee;

247 (5) The State Comptroller, or the comptroller's designee;

248 (6) The Secretary of the Office of Policy and Management, or the
249 secretary's designee, who shall also serve as a chairperson;

250 (7) The speaker of the House of Representatives, the president pro
251 tempore of the Senate, the majority leader of the House of
252 Representatives, the majority leader of the Senate, the minority leader
253 of the House of Representatives and the minority leader of the Senate,
254 or their designees;

255 (8) The House and Senate chairpersons of the joint standing
256 committee of the General Assembly having cognizance of matters
257 relating to human services, who, along with the Secretary of the Office
258 of Policy and Management, or the secretary's designee, shall serve as
259 chairpersons;

260 (9) The House and Senate chairpersons of the joint standing
261 committee of the General Assembly having cognizance of matters
262 relating to insurance and real estate, or their designees;

263 (10) The chief executive officer of Access Health Connecticut;

264 (11) Three health insurance experts from the nonprofit and academic
265 communities with demonstrated knowledge about health plan design
266 and actuarial practices, appointed by the chairpersons of the working
267 group; and

268 (12) Any other members the chairpersons deem necessary.

269 (c) Any member of the working group appointed under subdivisions
270 (11) and (12) of subsection (b) of this section may be a member of the
271 General Assembly. All initial appointments to the working group shall
272 be made not later than thirty days after the effective date of this section.
273 If such appointments are not made not later than thirty days after the
274 effective date of this section, the Secretary of the Office of Policy and
275 Management may designate individuals with the required
276 qualifications for the applicable appointment to serve on the working
277 group until such appointments are made.

278 (d) The working group may consult with stakeholders, including, but
279 not limited to, current enrollees in Access Health Connecticut, health
280 care providers, health insurance issuers, health care advocates,
281 researchers, actuaries and nonprofit health care service providers.

282 (e) Members appointed pursuant to subdivisions (11) and (12) of
283 subsection (b) of this section shall serve at the pleasure of the appointing
284 authority and shall continue to serve until their successors are
285 appointed. Any vacancy shall be filled by the appointing authority.

286 (f) A majority of the membership of the working group shall
287 constitute a quorum for the transaction of any business and any decision
288 shall be by a majority vote of those present at a meeting. The
289 chairpersons may establish such committees, subcommittees or other
290 entities as they deem necessary to further the purposes of the working
291 group. The working group may adopt rules of procedure.

292 (g) The members of the working group shall serve without
293 compensation, but shall, within the limits of available funds and subject

294 to the approval of the working group's chairpersons, be reimbursed for
295 expenses necessarily incurred in the performance of their duties.

296 (h) Not later than December 1, 2026, the working group shall submit
297 a report to the joint standing committees of the General Assembly
298 having cognizance of matters relating to appropriations and the budgets
299 of state agencies, human services and insurance and real estate
300 concerning the group's recommendations for the design and
301 implementation of the Connecticut Option program and the basic health
302 program. Such report shall contain a description of the programs,
303 including, but not limited to, operations and funding for the programs.

304 Sec. 8. (*Effective July 1, 2026*) Prior to implementation of the
305 Connecticut Option program and the basic health program, the
306 Secretary of the Office of Policy and Management shall hold at least one
307 public hearing for each program and a series of stakeholder engagement
308 meetings with potential stakeholders, including, but not limited to: (1)
309 Representatives of hospitals, health centers, other health care providers,
310 HUSKY Health plan enrollees and Access Health Connecticut enrollees,
311 (2) members of the joint standing committees of the General Assembly
312 having cognizance of matters relating to appropriations and the budgets
313 of state agencies, human services, public health and insurance and real
314 estate, and (3) other persons with health equity and health coverage
315 policy expertise.

316 Sec. 9. Section 46b-37 of the general statutes is repealed and the
317 following is substituted in lieu thereof (*Effective July 1, 2026*):

318 (a) Any purchase made by either a husband or wife in his or her own
319 name shall be presumed, in the absence of notice to the contrary, to be
320 made by him or her as an individual and he or she shall be liable for the
321 purchase.

322 (b) Notwithstanding the provisions of subsection (a) of this section, it
323 shall be the joint duty of each spouse to support his or her family, and
324 both, except as provided in subsection (d) of this section, shall be liable
325 for: (1) The reasonable and necessary services of a physician or dentist;

326 (2) hospital expenses rendered the husband or wife or minor child while
327 residing in the family of his or her parents; (3) the rental of any dwelling
328 unit actually occupied by the husband and wife as a residence and
329 reasonably necessary to them for that purpose; and (4) any article
330 purchased by either which has in fact gone to the support of the family,
331 or for the joint benefit of both.

332 (c) Notwithstanding the provisions of subsection (a) of this section, a
333 spouse who abandons his or her spouse without cause shall be liable for
334 the reasonable support of such other spouse while abandoned.

335 (d) Notwithstanding the provisions of subsection (b) of this section,
336 no spouse surviving after the death of a spouse shall be responsible for
337 the medical debt of the deceased spouse not covered by the estate of the
338 deceased spouse that is related to the (1) reasonable and necessary
339 services of a physician or dentist, or (2) hospital expenses.

340 [(d)] (e) No action may be maintained against either spouse under the
341 provisions of this section, either during or after any period of separation
342 from the other spouse, for any liability incurred by the other spouse
343 during the separation, if, during the separation the spouse who is liable
344 for support of the other spouse has provided the other spouse with
345 reasonable support.

346 [(e)] (f) Abandonment without cause by a spouse shall be a defense
347 to any liability pursuant to the provisions of subdivisions (1) to (4),
348 inclusive, of subsection (b) of this section for expenses incurred by and
349 for the benefit of such spouse. Nothing in this subsection shall affect the
350 duty of a parent to support his or her minor child.

351 Sec. 10. (NEW) (*Effective October 1, 2026*) (a) As used in this section,
352 (1) "hospital" has the same meaning as provided in section 19a-490 of
353 the general statutes, (2) "hospital financial assistance" means any
354 program administered by a hospital or health system, including a bed
355 fund, as defined in section 19a-509b of the general statutes, that reduces,
356 in whole or in part, a patient's liability for the cost of inpatient or
357 outpatient care, and (3) "hospital financial assistance program" means a

358 program in which a participating hospital provides inpatient and
359 outpatient care:

360 (A) At no cost to an uninsured patient with income not exceeding two
361 hundred per cent of the federal poverty level;

362 (B) Subsidized by hospital financial assistance for an uninsured
363 patient with income exceeding two hundred per cent of the federal
364 poverty level but not exceeding three hundred per cent of the federal
365 poverty level;

366 (C) Subsidized with hospital financial assistance for any patient with
367 income not exceeding four hundred per cent of the federal poverty level
368 who is enrolled in (i) the federal supplemental nutrition assistance
369 program, or (ii) the federal Special Supplemental Food Program for
370 Women, Infants and Children; and

371 (D) For patients with household income under two hundred per cent
372 of the federal poverty level who are deemed ineligible for hospital
373 financial assistance, billed in accordance with a payment schedule
374 amounting to not more than two per cent of such patient's annual
375 household income per year. After a cumulative thirty-six months of
376 payments by such patient, each participating hospital shall consider the
377 patient's hospital bill paid in full and permanently cease any and all
378 collection activities on any balance that remains unpaid.

379 (b) A hospital may opt in to the hospital financial assistance program
380 and be reimbursed pursuant to section 11 of this act. A participating
381 hospital shall not (1) count a patient's assets when determining
382 eligibility for hospital financial assistance, or (2) require the patient to
383 provide proof that the patient's application for benefits under the state
384 medical assistance program, Medicare, emergency Medicaid coverage,
385 other government-funded coverage or insurance through the
386 Connecticut Health Insurance Exchange was denied. A hospital shall
387 use software that conforms to industry standards concerning electronic
388 income verification and may accept one of the following documents to
389 verify income:

- 390 (A) A copy of the patient's most recent tax return;
- 391 (B) A copy of the patient's most recent W-2 form and 1099 forms;
- 392 (C) Copies of the patient's two most recent pay stubs; or
- 393 (D) Written income verification from an employer if the patient is
394 paid in cash.

395 (c) A participating hospital shall exempt patients who are
396 experiencing homelessness or are at imminent risk of homelessness
397 from providing documentation pursuant to subsection (b) of this section
398 but may require such patients to provide self-attested information for
399 both a hospital financial assistance screening and hospital financial
400 assistance application.

401 (d) Notwithstanding the provisions of section 19a-509b of the general
402 statutes, a participating hospital shall make information available on the
403 hospital financial assistance program in each of the top non-English
404 languages spoken by five or more per cent of the population that resides
405 in the geographic area served by the hospital. Such information shall (1)
406 be included in all discharge paperwork and on the hospital's Internet
407 web site, (2) contain contact information for the Office of the Healthcare
408 Advocate, and (3) comply with requirements concerning effective
409 communications under the Americans with Disabilities Act, including,
410 but not limited to, communications delivered through relay services,
411 interpretation, large print and braille.

412 Sec. 11. (NEW) (*Effective October 1, 2026*) (a) As used in this section,
413 "disproportionate share hospital payment" means a Medicaid payment
414 to a hospital that serves a disproportionately large number of Medicaid
415 beneficiaries and uninsured individuals. The Commissioner of Social
416 Services shall amend the Medicaid state plan to use disproportionate
417 share hospital payments to compensate hospitals that participate in the
418 hospital financial assistance program established pursuant to section 10
419 of this act.

420 (b) The Commissioner of Social Services shall establish criteria for a

421 participating hospital to document hospital financial assistance and
422 receive timely payment for such assistance.

423 (c) A hospital aggrieved by a final decision of the commissioner on
424 the validity of such hospital's bills for hospital financial assistance may
425 file an appeal in accordance with the provisions of section 17b-238 of the
426 general statutes, as amended by this act.

427 Sec. 12. (NEW) (*Effective from passage*) (a) As used in this section and
428 sections 13 and 15 of this act, "community engagement requirement"
429 means a federal requirement for certain Medicaid beneficiaries to work,
430 participate in a work-related program or community service or enroll in
431 an education program pursuant to Section 71119 of P.L. 119-21. There is
432 established a safety net mitigation working group that shall advise on,
433 monitor and coordinate the state's response to significant changes in
434 federal law or policy that impact public health, social services or other
435 safety net programs.

436 (b) The working group shall consist of the following members:

437 (1) The Secretary of the Office of Policy and Management, or the
438 secretary's designee;

439 (2) The Commissioners of Social Services, Revenue Services, Mental
440 Health and Addiction Services, Developmental Services and Public
441 Health, the Insurance Commissioner and the Labor Commissioner, or
442 their designees;

443 (3) The chairpersons of the joint standing committees of the General
444 Assembly having cognizance of matters relating to appropriations and
445 the budgets of state agencies, human services, housing and insurance
446 and real estate, or their designees, who shall jointly choose the
447 chairpersons of the working group;

448 (4) One person with expertise in health and human services policy
449 administration, one person with expertise in data science, analytics or
450 interagency data integration and one person with expertise in user
451 experience or person-centered design of such programs, all appointed

452 jointly by and serving at the pleasure of the chairpersons of the working
453 group;

454 (5) The chief executive officer of Access Health Connecticut, as
455 defined in section 4 of this act;

456 (6) The executive director of the Commission on Racial Equity in
457 Public Health; and

458 (7) Any other member that the chairpersons deem necessary.

459 (c) The working group shall:

460 (1) Convene not later than thirty days after the effective date of this
461 section;

462 (2) Review any significant changes in federal law or policy that
463 impact public health, social services or other safety net programs;

464 (3) Evaluate the current or projected operational and fiscal impacts of
465 such changes on agency procurement and service delivery;

466 (4) Recommend budgetary, regulatory, administrative or legislative
467 measures to mitigate adverse procurement or service outcomes to the
468 Office of Policy and Management and the joint standing committees of
469 the General Assembly having cognizance of matters relating to
470 appropriations and the budgets of state agencies, human services,
471 housing and insurance and real estate; and

472 (5) Solicit input from stakeholders, including municipal governments
473 and community-based providers, and independent experts such as
474 academic researchers and policy organizations, as necessary.

475 (d) Not later than February 1, 2027, and annually thereafter, the
476 working group shall submit a report, in accordance with the provisions
477 of section 11-4a of the general statutes, to the joint standing committees
478 of the General Assembly having cognizance of matters relating to
479 appropriations and the budgets of state agencies, human services,
480 housing and insurance and real estate. Such report shall include:

481 (1) An estimate of the number and percentage of Medicaid and
482 supplemental nutrition assistance program beneficiaries in the state
483 who may qualify for exemptions from work or community engagement
484 requirements imposed by the federal Fiscal Responsibility Act of 2023,
485 P.L. 118-5 and Section 71119 of P.L. 119-21;

486 (2) A review of current state and federal data systems used to
487 determine or verify:

488 (A) Whether an individual qualifies for an exemption from work
489 requirements under the supplemental nutrition assistance program or
490 from community engagement requirements under Medicaid, including
491 exemptions based on disability status or other allowable criteria; and

492 (B) Whether an individual has met the work requirements for the
493 supplemental nutrition assistance program or the community
494 engagement requirements for Medicaid;

495 (3) A review of any application by the state for grants from the Rural
496 Health Transformation Program or federal technical assistance funding;
497 and

498 (4) Recommendations for establishing a structured and sustainable
499 system to support interagency data sharing, beneficiary identification
500 and administrative practices that maximize the application of allowable
501 exemptions under federal law.

502 Sec. 13. (NEW) (*Effective from passage*) The Commissioner of Social
503 Services, in consultation with the Labor Commissioner, shall, not later
504 than thirty days after the effective date of this section, and monthly
505 thereafter, file a report, in accordance with the provisions of section 11-
506 4a of the general statutes, with the joint standing committee of the
507 General Assembly having cognizance of matters relating to human
508 services on:

509 (1) Implementation of federal law concerning work and community
510 engagement requirements for Medicaid and supplemental nutrition
511 assistance beneficiaries under P.L. 119-21;

512 (2) The number of beneficiaries who have lost and are expected to
513 lose eligibility for the supplemental nutrition assistance and Medicaid
514 programs since implementation of such requirements under P.L. 119-21;

515 (3) Copies of any documentation or reporting provided to the federal
516 government related to the new requirements;

517 (4) A list of changes to contracts with existing vendors and requests
518 for proposals for new vendors concerning implementation of the new
519 requirements;

520 (5) A list of data sources being leveraged for automatic verification of
521 work or income status or qualifications for exemptions from the new
522 federal requirements;

523 (6) Records related to how the Department of Social Services will
524 define "medical frailty" pursuant to section 16 of this act for the purposes
525 of potential exemptions from the requirements;

526 (7) Records related to how verification of compliance with the
527 requirements will be streamlined for recipients of supplemental
528 nutrition assistance and Medicaid;

529 (8) A summary of how Medicaid and supplemental nutrition
530 assistance recipients will be engaged in the decision-making process;

531 (9) A long-term plan for ongoing dissemination of information and
532 support for Medicaid and supplemental nutrition assistance recipients
533 and providers to minimize disenrollment of eligible individuals; and

534 (10) Statistics concerning the Department of Social Services' customer
535 service telephone call center, including, but not limited to, average
536 response time to telephone calls by staff, call abandonment rate, level of
537 staff attrition and details on new staff hired in the past fiscal year.

538 Sec. 14. (NEW) (*Effective from passage*) (a) As used in this section and
539 section 15 of this act:

540 (1) "HUSKY Health program" means the Medicaid and Children's

541 Health Insurance Program administered by the Department of Social
542 Services pursuant to sections 17b-261 and 17b-292 of the general statutes
543 and any related state plan amendments or waivers approved by the
544 federal Centers for Medicare and Medicaid Services.

545 (2) "SNAP" means the supplemental nutrition assistance program
546 administered by the Department of Social Services pursuant to title 17b
547 of the general statutes and the federal Food and Nutrition Act of 2008,
548 as amended from time to time.

549 (b) Whenever any federal statute, regulation, rule or administrative
550 guidance is enacted, adopted or issued that the Secretary of the Office
551 of Policy and Management, in consultation with the Commissioner of
552 Social Services, determines is likely to significantly affect federal
553 funding levels, program enrollment and eligibility requirements for or
554 administrative operations of the HUSKY Health program or SNAP, the
555 secretary shall send written notice to the joint standing committees of
556 the General Assembly having cognizance of matters relating to
557 appropriations and the budgets of state agencies and human services.
558 The secretary shall include recommendations in the notice of state
559 statutes or regulations that may need to be amended to preserve access
560 to and maximize the number of persons eligible for such programs.

561 (c) The committees may hold a public hearing not later than fourteen
562 days after receiving such notice and any recommendations from the
563 secretary.

564 Sec. 15. (NEW) (*Effective from passage*) (a) The Department of Social
565 Services shall, for the purposes of administering public assistance
566 programs, including, but not limited to, the HUSKY Health program
567 and SNAP, receive or have access to data maintained by other state
568 agencies, including, but not limited to, the Labor Department, the
569 Department of Public Health, the Department of Education and the
570 Office of Higher Education. The department's use of such data shall
571 include, but need not be limited to:

572 (1) Determining whether an individual qualifies for an exemption

573 from work requirements under SNAP or from Medicaid community
574 engagement requirements;

575 (2) When an individual is not exempt, verifying compliance with
576 applicable work or community engagement requirements;

577 (3) Identifying and implementing any other uses of interagency data
578 that facilitate effective program administration; and

579 (4) Identifying and implementing additional uses of interagency data
580 that streamline eligibility and enrollment processes in order to mitigate
581 new barriers to access caused by changes in federal law.

582 (b) Data accessible to the Department of Social Services pursuant to
583 subsection (a) of this section shall include, but need not be limited to:

584 (1) Employment and wage records maintained by the Labor
585 Department;

586 (2) Vital records, including, but not limited to, records of birth, death,
587 guardianship and dependency, maintained by the Department of Public
588 Health;

589 (3) Enrollment and attendance records from secondary and
590 postsecondary educational institutions, maintained by the State
591 Department of Education or the Office of Higher Education; and

592 (4) Any other data maintained by a state agency that the Department
593 of Social Services determines is necessary to verify exemption eligibility
594 criteria established under federal law or guidance.

595 (c) To the extent permissible under federal law, the Department of
596 Social Services may (1) verify employment and community engagement
597 status of beneficiaries of Medicaid and SNAP using self-attestation by
598 beneficiaries, and (2) waive such requirements for beneficiaries with
599 medical frailty in accordance with the definition and documentation of
600 medical frailty prescribed by the commissioner pursuant to section 16
601 of this act.

602 (d) The Department of Social Services shall use any such data
603 received pursuant to this section solely for the purposes of: (1)
604 Identifying and verifying whether an individual qualifies for an
605 exemption from work requirements under the supplemental nutrition
606 assistance program or from community engagement requirements
607 under Medicaid; and (2) determining whether an individual has met
608 such work or community engagement requirements in order to facilitate
609 enrollment and automatic renewal of eligibility. No such data shall be
610 disclosed by the department except as otherwise authorized by state or
611 federal law.

612 (e) The department shall notify the joint standing committee of the
613 General Assembly having cognizance of matters relating to human
614 services in writing prior to disclosing any data pursuant to this section.
615 Such notification shall include identification of (1) any person or entity
616 who is the intended recipient of such disclosed data, and (2) the legal
617 authority permitting such disclosure. All data use and data-sharing
618 activities conducted pursuant to this section shall comply with all
619 applicable state and federal laws governing confidentiality, privacy and
620 security, including, but not limited to:

621 (1) The Health Insurance Portability and Accountability Act of 1996
622 (HIPAA), 42 USC 1320d et seq.;

623 (2) The Family Educational Rights and Privacy Act of 1974 (FERPA),
624 20 USC 1232g;

625 (3) 42 CFR Part 2, concerning the confidentiality of substance use
626 disorder treatment records;

627 (4) Section 17b-90 of the general statutes;

628 (5) Section 4-67n of the general statutes; and

629 (6) Any other applicable state or federal law governing data privacy,
630 confidentiality or security.

631 (f) To the extent permissible under federal law, the Department of

632 Social Services may establish a system under which applicants and
633 beneficiaries of the HUSKY Health program and SNAP are asked, at the
634 time of application or renewal, to provide consent for the department to
635 access and use data maintained by other agencies in order to determine
636 or renew eligibility.

637 (g) The Department of Social Services shall enter into interagency
638 data-sharing agreements with each agency from which data is accessed
639 or received pursuant to this section. Each such agreement shall specify:

640 (1) The categories of data to be shared;

641 (2) The purpose and manner of use of such data;

642 (3) Procedures for ensuring data security and compliance with
643 applicable privacy laws; and

644 (4) Limitations on further use or disclosure of such data.

645 (h) To the extent permissible under federal law and within available
646 appropriations, the Department of Social Services may establish a
647 program to facilitate enrollment in and automatic renewal of eligibility
648 for Medicaid or SNAP by accepting information submitted by
649 employers, nonprofits and other organizations in accordance with
650 federal law, regulation or guidance on behalf of their employees, clients,
651 volunteers or other related parties for the purposes of verifying whether
652 an individual has met work or community engagement requirements.

653 Sec. 16. (*Effective from passage*) (a) The Commissioner of Social Services
654 shall develop a state definition of "medical frailty" in advance of new
655 federal guidance on use of the classification for the purpose of
656 exemptions from work and community engagement requirements for
657 Medicaid and the supplemental nutrition assistance program.

658 (b) The commissioner shall take into consideration existing
659 definitions in state statutes and regulations relating to similar physical
660 conditions, definitions of medical frailty in other states, related medical
661 codes needed to diagnose such classification and ways to streamline

662 such classification across programs administered by the commissioner
663 that enroll medically frail individuals. The commissioner shall file a
664 report, in accordance with the provisions of section 11-4a of the general
665 statutes, not later than sixty days after the effective date of this section
666 with the joint standing committee of the General Assembly having
667 cognizance of matters relating to human services on a proposed
668 definition of medical frailty.

669 Sec. 17. (NEW) (*Effective July 1, 2026*) (a) The Commissioner of Social
670 Services shall submit any proposal to change the fee-for-service
671 Medicaid payment model to a managed care payment model to the joint
672 standing committees of the General Assembly having cognizance of
673 matters relating to human services and appropriations and the budgets
674 of state agencies for approval, denial or modification before
675 implementing such change or seeking any necessary federal approval to
676 implement such change. Not later than thirty days after the date of their
677 receipt of such proposal, such joint standing committees shall hold a
678 public hearing on the proposal. Not later than fifteen days before such
679 hearing, such joint standing committees shall inform the commissioner,
680 in writing, of the date and time of such hearing and invite the
681 commissioner to testify on the reasons for such proposal, including, but
682 not limited to, (1) any costs or benefits to the state, (2) the expected
683 impact on care provided to Medicaid recipients, and (3) the expected
684 impact on Medicaid reimbursements to providers of such care. At the
685 conclusion of such hearing, such joint standing committees shall vote on
686 whether to approve, deny or modify such proposal. The joint standing
687 committees shall advise the commissioner of their approval, denial or
688 modifications, if any, of the commissioner's proposal. If such joint
689 standing committees advise the commissioner of their denial, the
690 commissioner shall not implement the proposal or seek any necessary
691 federal approval to implement the proposal.

692 (b) If such joint standing committees do not concur, the committee
693 chairpersons shall appoint a committee of conference, which shall be
694 composed of three members from each joint standing committee. At
695 least one member appointed from each joint standing committee shall

696 be a member of the minority party. The report of the committee of
697 conference shall be made to each joint standing committee, which shall
698 vote to accept or reject the report. The report of the committee of
699 conference may not be amended. If one joint standing committee rejects
700 the report of the committee of conference, the proposal shall be deemed
701 denied. If such joint standing committees accept the report, the
702 committee having cognizance of matters relating to appropriations and
703 the budgets of state agencies shall advise the commissioner of their
704 approval, denial or modifications, if any, of the commissioner's
705 proposal. If such joint standing committees do not so advise the
706 commissioner during the thirty-day period, the proposal shall be
707 deemed denied.

708 (c) Any application for a federal waiver, waiver renewal or proposed
709 Medicaid state plan amendment submitted to the federal government
710 by the commissioner to implement a proposal under subsection (a) of
711 this section shall be in accordance with the approval or modifications, if
712 any, of the joint standing committees of the General Assembly having
713 cognizance of matters relating to human services and appropriations
714 and the budgets of state agencies.

715 (d) Thirty days prior to submission of such proposal to such joint
716 standing committees pursuant to subsection (a) of this section, the
717 Commissioner of Social Services shall post a notice that the
718 commissioner intends to seek approval for such proposal on the
719 Department of Social Services' Internet web site, along with a summary
720 of the provisions of such proposal and the manner in which individuals
721 may submit comments. The commissioner shall allow thirty days for
722 written comments on such proposal and shall include all written
723 comments with the submission of such proposal to such joint standing
724 committees.

725 (e) The commissioner shall include with any application for federal
726 approval of such proposal: (1) Any written comments received pursuant
727 to subsection (d) of this section; and (2) any additional written
728 comments submitted to such joint standing committees at such

729 proceedings. Such joint standing committees shall transmit any such
730 materials to the commissioner for inclusion with any such application
731 for federal approval.

732 Sec. 18. Section 38a-591d of the general statutes is repealed and the
733 following is substituted in lieu thereof (*Effective January 1, 2027*):

734 (a) (1) Each health carrier shall maintain written procedures for (A)
735 utilization review and benefit determinations, (B) expedited utilization
736 review and benefit determinations with respect to prospective urgent
737 care requests and concurrent review urgent care requests, and (C)
738 notifying covered persons or covered persons' authorized
739 representatives of such review and benefit determinations. Each health
740 carrier shall make such review and benefit determinations within the
741 specified time periods under this section.

742 (2) In determining whether a benefit request shall be considered an
743 urgent care request, an individual acting on behalf of a health carrier
744 shall apply the judgment of a prudent layperson who possesses an
745 average knowledge of health and medicine, except that any benefit
746 request (A) determined to be an urgent care request by a health care
747 professional with knowledge of the covered person's medical condition,
748 or (B) specified under subparagraph (B) or (C) of subdivision (38) of
749 section 38a-591a shall be deemed an urgent care request.

750 (3) (A) At the time a health carrier notifies a covered person, a covered
751 person's authorized representative or a covered person's health care
752 professional of an initial adverse determination that was based, in whole
753 or in part, on medical necessity, of a concurrent or prospective
754 utilization review or of a benefit request, the health carrier shall notify
755 the covered person's health care professional (i) of the opportunity for a
756 conference as provided in subparagraph (B) of this subdivision, and (ii)
757 that such conference shall not be considered a grievance of such initial
758 adverse determination as long as a grievance has not been filed as set
759 forth in subparagraph (B) of this subdivision.

760 (B) After a health carrier notifies a covered person, a covered person's

761 authorized representative or a covered person's health care professional
762 of an initial adverse determination that was based, in whole or in part,
763 on medical necessity, of a concurrent or prospective utilization review
764 or of a benefit request, the health carrier shall offer a covered person's
765 health care professional the opportunity to confer, at the request of the
766 covered person's health care professional, with a clinical peer of such
767 health carrier, provided such covered person, covered person's
768 authorized representative or covered person's health care professional
769 has not filed a grievance of such initial adverse determination prior to
770 such conference. Such conference shall not be considered a grievance of
771 such initial adverse determination. Such health carrier shall grant such
772 clinical peer the authority to reverse such initial adverse determination.

773 (b) With respect to a nonurgent care request:

774 (1) (A) For a prospective or concurrent review request, a health carrier
775 shall make a determination within a reasonable period of time
776 appropriate to the covered person's medical condition, but not later than
777 [seven calendar] two business days after the date the health carrier
778 receives such request, and shall notify the covered person and, if
779 applicable, the covered person's authorized representative of such
780 determination, whether or not the carrier certifies the provision of the
781 benefit.

782 (B) If the review under subparagraph (A) of this subdivision is a
783 review of a grievance involving a concurrent review request, pursuant
784 to 45 CFR 147.136, as amended from time to time, the treatment shall be
785 continued without liability to the covered person until the covered
786 person has been notified of the review decision. A health carrier shall
787 acknowledge receipt of a nonurgent prior authorization request not
788 later than twenty-four hours after receipt and shall inform the covered
789 person, authorized representative or health care provider, as applicable,
790 at that time if any information is missing that is necessary to make a
791 determination on the request.

792 (C) If a health carrier notifies a covered person, authorized
793 representative or health care provider pursuant to subparagraph (B) of

794 this subdivision that additional information is necessary, the health
795 carrier shall approve or deny the prior authorization request not later
796 than twenty-four hours after receipt of such information.

797 (2) For a retrospective review request, a health carrier shall make a
798 determination within a reasonable period of time, but not later than
799 thirty calendar days after the date the health carrier receives such
800 request.

801 (3) (A) The time period specified in subdivision (1) of this subsection
802 may be extended once by the health carrier for up to five calendar days,
803 and the time period specified in subdivision (2) of this subsection may
804 be extended once by the health carrier for up to fifteen calendar days,
805 provided the health carrier:

806 (i) Determines that an extension is necessary due to circumstances
807 beyond the health carrier's control; and

808 (ii) Notifies the covered person and, if applicable, the covered
809 person's authorized representative prior to the expiration of the initial
810 time period, of the circumstances requiring the extension of time and
811 the date by which the health carrier expects to make a determination.

812 (B) Notwithstanding the provisions of subparagraph (A) of this
813 subdivision, [(3) of this subsection,] the time period specified in
814 subdivision (1) of this subsection may be extended once by the health
815 carrier for up to fifteen calendar days, provided the covered person's
816 health care professional notifies the health carrier that the service will
817 not be performed for at least three months from the date such health
818 carrier received the request.

819 (4) (A) If the extension pursuant to subdivision (3) of this subsection
820 is necessary due to the failure of the covered person or the covered
821 person's authorized representative to provide information necessary to
822 make a determination on the request, the health carrier shall:

823 (i) Specifically describe in the notice of extension the required
824 information necessary to complete the request; and

825 (ii) Provide the covered person and, if applicable, the covered
826 person's authorized representative with not less than forty-five calendar
827 days after the date of receipt of the notice to provide the specified
828 information.

829 (B) If the covered person or the covered person's authorized
830 representative fails to submit the specified information before the end
831 of the period of the extension, the health carrier may deny certification
832 of the benefit requested.

833 (c) With respect to an urgent care request:

834 (1) (A) Unless the covered person or the covered person's authorized
835 representative has failed to provide information necessary for the health
836 carrier to make a determination and except as specified under
837 subparagraph (B) of this subdivision, the health carrier shall make a
838 determination as soon as possible, taking into account the covered
839 person's medical condition, but not later than twenty-four hours after
840 the health carrier receives such request, provided, if the urgent care
841 request is a concurrent review request to extend a course of treatment
842 beyond the initial period of time or the number of treatments, such
843 request is made not less than twenty-four hours prior to the expiration
844 of the prescribed period of time or number of treatments. For an urgent
845 prior authorization request, a health carrier shall approve, deny or
846 inform the covered person, the covered person's authorized
847 representative or the prescribing health care provider if any information
848 is missing from the prior authorization request not later than twenty-
849 four hours after receipt of such request.

850 (B) Unless the covered person or the covered person's authorized
851 representative has failed to provide information necessary for the health
852 carrier to make a determination, for an urgent care request specified
853 under subparagraph (B) or (C) of subdivision (38) of section 38a-591a,
854 the health carrier shall make a determination as soon as possible, taking
855 into account the covered person's medical condition, but not later than
856 twenty-four hours after the health carrier receives such request,
857 provided, if the urgent care request is a concurrent review request to

858 extend a course of treatment beyond the initial period of time or the
859 number of treatments, such request is made not less than twenty-four
860 hours prior to the expiration of the prescribed period of time or number
861 of treatments.

862 (2) (A) If the covered person or the covered person's authorized
863 representative has failed to provide information necessary for the health
864 carrier to make a determination, the health carrier shall notify the
865 covered person or the covered person's representative, as applicable, as
866 soon as possible, but not later than twenty-four hours after the health
867 carrier receives such request. If a health carrier informs a covered
868 person, authorized representative or health care provider that
869 additional information is necessary for the health carrier to make a
870 determination on an urgent prior authorization request, the health
871 carrier shall approve or deny the request not later than twenty-four
872 hours after receipt of the necessary information.

873 (B) The health carrier shall provide the covered person or the covered
874 person's authorized representative, as applicable, a reasonable period of
875 time to submit the specified information, taking into account the
876 covered person's medical condition, but not less than forty-eight hours
877 after notifying the covered person or the covered person's authorized
878 representative, as applicable.

879 (3) The health carrier shall notify the covered person and, if
880 applicable, the covered person's authorized representative of its
881 determination as soon as possible, but not later than forty-eight hours
882 after the earlier of (A) the date on which the covered person and the
883 covered person's authorized representative, as applicable, provides the
884 specified information to the health carrier, or (B) the date on which the
885 specified information was to have been submitted.

886 (d) (1) If a health carrier fails, within the time periods specified in
887 subsections (b) and (c) of this section, to approve or deny a completed
888 prior authorization request, acknowledge receipt of the request or notify
889 the covered person, authorized representative or health care provider
890 that additional information is required, the prior authorization request

891 shall be deemed approved. Whenever a health carrier receives a review
892 request from a covered person or a covered person's authorized
893 representative that fails to meet the health carrier's filing procedures, the
894 health carrier shall notify the covered person and, if applicable, the
895 covered person's authorized representative of such failure not later than
896 five calendar days after the health carrier receives such request, except
897 that for an urgent care request, the health carrier shall notify the covered
898 person and, if applicable, the covered person's authorized
899 representative of such failure not later than twenty-four hours after the
900 health carrier receives such request. For a nonurgent prospective or
901 concurrent review request, each health carrier shall acknowledge receipt
902 of each such request as soon as practicable, but not later than twenty-
903 four hours after the health carrier receives such request, except that such
904 health carrier shall respond in less time if such a response is required by
905 applicable federal law.

906 (2) If the health carrier provides such notice orally, the health carrier
907 shall provide confirmation in writing to the covered person and the
908 covered person's health care professional of record not later than three
909 calendar days after providing the oral notice. No health carrier shall
910 require a health care professional or hospital to submit additional
911 information that was not reasonably available to such health care
912 professional or hospital at the time that such health care professional or
913 hospital filed the prospective or concurrent review request with such
914 health carrier.

915 (e) (1) Any service for which prior authorization was required and
916 received, including deemed approvals, shall be paid in accordance with
917 state and federal prompt payment laws. A health carrier shall pay claims
918 for health care services for which prior authorization was required by
919 and received from the health carrier, including any prior authorization
920 deemed approved pursuant to subsection (d) of this section, except
921 where: (A) The covered person was not eligible for coverage at the time
922 services were rendered; (B) benefits were exhausted; (C) the prior
923 authorization was based on materially inaccurate information provided
924 by the health care provider; (D) the health carrier has a reasonable belief

925 that fraud or intentional misconduct occurred; or (E) another health
926 carrier is responsible pursuant to coordination of benefits. Prior
927 authorization approval, whether express or deemed approved, shall
928 constitute a binding determination with respect to coverage and
929 payment. Each health carrier shall provide promptly to a covered
930 person and, if applicable, the covered person's authorized
931 representative a notice of an adverse determination.

932 [(1)] (2) Such notice may be provided in writing or by electronic
933 means and shall set forth, in a manner calculated to be understood by
934 the covered person or the covered person's authorized representative:

935 (A) Information sufficient to identify the benefit request or claim
936 involved, including the date of service, if applicable, the health care
937 professional and the claim amount;

938 (B) The specific reason or reasons for the adverse determination,
939 including, upon request, a listing of the relevant clinical review criteria,
940 including professional criteria and medical or scientific evidence and a
941 description of the health carrier's standard, if any, that were used in
942 reaching the denial;

943 (C) Reference to the specific health benefit plan provisions on which
944 the determination is based;

945 (D) A description of any additional material or information necessary
946 for the covered person to perfect the benefit request or claim, including
947 an explanation of why the material or information is necessary to perfect
948 the request or claim;

949 (E) A description of the health carrier's internal grievance process that
950 includes (i) the health carrier's expedited review procedures, (ii) any
951 time limits applicable to such process or procedures, (iii) the contact
952 information for the organizational unit designated to coordinate the
953 review on behalf of the health carrier, and (iv) a statement that the
954 covered person or, if applicable, the covered person's authorized
955 representative is entitled, pursuant to the requirements of the health

956 carrier's internal grievance process, to receive from the health carrier,
957 free of charge upon request, reasonable access to and copies of all
958 documents, records, communications and other information and
959 evidence regarding the covered person's benefit request;

960 (F) (i) (I) A copy of the specific rule, guideline, protocol or other
961 similar criterion the health carrier relied upon to make the adverse
962 determination, or (II) a statement that a specific rule, guideline, protocol
963 or other similar criterion of the health carrier was relied upon to make
964 the adverse determination and that a copy of such rule, guideline,
965 protocol or other similar criterion will be provided to the covered person
966 free of charge upon request, with instructions for requesting such copy,
967 and (ii) the links to such rule, guideline, protocol or other similar
968 criterion on such health carrier's Internet web site;

969 (G) If the adverse determination is based on medical necessity or an
970 experimental or investigational treatment or similar exclusion or limit,
971 the written statement of the scientific or clinical rationale for the adverse
972 determination and (i) an explanation of the scientific or clinical rationale
973 used to make the determination that applies the terms of the health
974 benefit plan to the covered person's medical circumstances, or (ii) a
975 statement that an explanation will be provided to the covered person
976 free of charge upon request, and instructions for requesting a copy of
977 such explanation;

978 (H) A statement explaining the right of the covered person to contact
979 the commissioner's office or the Office of the Healthcare Advocate at
980 any time for assistance or, upon completion of the health carrier's
981 internal grievance process, to file a civil action in a court of competent
982 jurisdiction. Such statement shall include the contact information for
983 said offices; and

984 (I) A statement, expressed in language approved by the Healthcare
985 Advocate and prominently displayed on the first page or cover sheet of
986 the notice using a call-out box and large or bold text, that if the covered
987 person or the covered person's authorized representative chooses to file
988 a grievance of an adverse determination, (i) such appeals are sometimes

989 successful, (ii) such covered person or covered person's authorized
990 representative may benefit from free assistance from the Office of the
991 Healthcare Advocate, which can assist such covered person or covered
992 person's authorized representative with the filing of a grievance
993 pursuant to 42 USC 300gg-93, as amended from time to time, (iii) such
994 covered person or covered person's authorized representative is entitled
995 and encouraged to submit supporting documentation for the health
996 carrier's consideration during the review of an adverse determination,
997 including narratives from such covered person or covered person's
998 authorized representative and letters and treatment notes from such
999 covered person's health care professional, and (iv) such covered person
1000 or covered person's authorized representative has the right to ask such
1001 covered person's health care professional for such letters or treatment
1002 notes.

1003 [(2)] (3) Upon request pursuant to subparagraph (E) of subdivision
1004 [(1)] (2) of this subsection, the health carrier shall provide such copies in
1005 accordance with subsection (a) of section 38a-591n, as amended by this
1006 act.

1007 (f) If the adverse determination is a rescission, the health carrier shall
1008 include with the advance notice of the application for rescission
1009 required to be sent to the covered person, a written statement that
1010 includes:

1011 (1) Clear identification of the alleged fraudulent act, practice or
1012 omission or the intentional misrepresentation of material fact;

1013 (2) An explanation as to why the act, practice or omission was
1014 fraudulent or was an intentional misrepresentation of a material fact;

1015 (3) A disclosure that the covered person or the covered person's
1016 authorized representative may file immediately, without waiting for the
1017 date such advance notice of the proposed rescission ends, a grievance
1018 with the health carrier to request a review of the adverse determination
1019 to rescind coverage, pursuant to sections 38a-591e and 38a-591f;

1020 (4) A description of the health carrier's grievance procedures
1021 established under sections 38a-591e and 38a-591f, including any time
1022 limits applicable to those procedures; and

1023 (5) The date such advance notice of the proposed rescission ends and
1024 the date back to which the coverage will be retroactively rescinded.

1025 (g) (1) Whenever a health carrier fails to strictly adhere to the
1026 requirements of this section with respect to making utilization review
1027 and benefit determinations of a benefit request or claim, the covered
1028 person shall be deemed to have exhausted the internal grievance
1029 process of such health carrier and may file a request for an external
1030 review in accordance with the provisions of section 38a-591g, regardless
1031 of whether the health carrier asserts it substantially complied with the
1032 requirements of this section or that any error it committed was de
1033 minimis.

1034 (2) A covered person who has exhausted the internal grievance
1035 process of a health carrier may, in addition to filing a request for an
1036 external review, pursue any available remedies under state or federal
1037 law on the basis that the health carrier failed to provide a reasonable
1038 internal grievance process that would yield a decision on the merits of
1039 the claim.

1040 Sec. 19. Subsection (b) of section 17b-238 of the 2026 supplement to
1041 the general statutes is repealed and the following is substituted in lieu
1042 thereof (*Effective October 1, 2026*):

1043 (b) Any institution or agency to which payments are to be made
1044 under sections 17b-239 to 17b-246, inclusive, and sections 17b-340, [and]
1045 17b-343 and section 11 of this act which is aggrieved by any decision of
1046 said commissioner may, within ten days after written notice thereof
1047 from the commissioner, obtain, by written request to the commissioner,
1048 a rehearing on all items of aggrievement. On and after July 1, 1996, a
1049 rehearing shall be held by the commissioner or his designee, provided a
1050 detailed written description of all such items is filed within ninety days
1051 of written notice of the commissioner's decision. The rehearing shall be

1052 held within thirty days of the filing of the detailed written description
1053 of each specific item of aggrievement. The commissioner shall issue a
1054 final decision within sixty days of the close of evidence or the date on
1055 which final briefs are filed, whichever occurs later. Any designee of the
1056 commissioner who presides over such rehearing shall be impartial and
1057 shall not be employed within the Department of Social Services office of
1058 certificate of need and rate setting. Any such items not resolved at such
1059 rehearing to the satisfaction of either such institution or agency or said
1060 commissioner shall be submitted to binding arbitration to an arbitration
1061 board consisting of one member appointed by the institution or agency,
1062 one member appointed by the commissioner and one member
1063 appointed by the Chief Court Administrator from among the retired
1064 judges of the Superior Court, which retired judge shall be compensated
1065 for his services on such board in the same manner as a state referee is
1066 compensated for his services under section 52-434. The proceedings of
1067 the arbitration board and any decisions rendered by such board shall be
1068 conducted in accordance with the provisions of the Social Security Act,
1069 49 Stat. 620 (1935), 42 USC 1396, as amended from time to time, and
1070 chapter 54.

1071 Sec. 20. Subsection (b) of section 17b-238 of the 2026 supplement to
1072 the general statutes, as amended by section 348 of public act 25-168, is
1073 repealed and the following is substituted in lieu thereof (*Effective January*
1074 *1, 2027*):

1075 (b) Any institution or agency to which payments are to be made
1076 under sections 17b-239 to 17b-246, inclusive, and sections 17b-340, [and]
1077 17b-343 and section 11 of this act which is aggrieved by any decision of
1078 said commissioner may, within ten days after written notice thereof
1079 from the commissioner, obtain, by written request to the commissioner,
1080 a rehearing on all items of aggrievement. On and after July 1, 1996, a
1081 rehearing shall be held by the commissioner or his designee, provided a
1082 detailed written description of all such items is filed within ninety days
1083 of written notice of the commissioner's decision. The rehearing shall be
1084 held within thirty days of the filing of the detailed written description
1085 of each specific item of aggrievement. The commissioner shall issue a

1086 final decision within sixty days of the close of evidence or the date on
1087 which final briefs are filed, whichever occurs later. Any designee of the
1088 commissioner who presides over such rehearing shall be impartial and
1089 shall not be employed within the Department of Social Services office of
1090 certificate of need and rate setting. Any such items not resolved at such
1091 rehearing to the satisfaction of either such institution or agency or said
1092 commissioner may be appealed in accordance with section 4-183. Such
1093 appeals shall be privileged cases to be heard by the court as soon after
1094 the return date as shall be practicable.

1095 Sec. 21. Subparagraph (C) of subdivision (2) of subsection (a) of
1096 section 38a-591c of the general statutes is repealed and the following is
1097 substituted in lieu thereof (*Effective January 1, 2027*):

1098 (C) Each health carrier shall (i) post on its Internet web site (I) any
1099 clinical review criteria it uses, and (II) links to any rule, guideline,
1100 protocol or other similar criterion a health carrier may rely upon to make
1101 an adverse determination as described in subparagraph (F) of
1102 subdivision [(1)] (2) of subsection (e) of section 38a-591d, as amended by
1103 this act, and (ii) make its clinical review criteria available upon request
1104 to authorized government agencies.

1105 Sec. 22. Subdivision (1) of subsection (a) of section 38a-591n of the
1106 general statutes is repealed and the following is substituted in lieu
1107 thereof (*Effective January 1, 2027*):

1108 (a) (1) Upon request pursuant to subparagraph (E) of subdivision [(1)]
1109 (2) of subsection (e) of section 38a-591d, as amended by this act, the
1110 health carrier shall provide free of charge to a covered person or a
1111 covered person's authorized representative, as applicable, copies of all
1112 documents, communications, information and evidence, including
1113 citations to any medical journals, regarding the covered person's benefit
1114 request that is the subject of the adverse determination that were not
1115 submitted by the covered person or the covered person's authorized
1116 representative and were available to the health carrier or the utilization
1117 review entity that made the adverse determination at the time such
1118 adverse determination was made.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2026</i>	New section
Sec. 2	<i>July 1, 2026</i>	3-13c
Sec. 3	<i>July 1, 2026</i>	New section
Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>from passage</i>	New section
Sec. 6	<i>July 1, 2026</i>	New section
Sec. 7	<i>from passage</i>	New section
Sec. 8	<i>July 1, 2026</i>	New section
Sec. 9	<i>July 1, 2026</i>	46b-37
Sec. 10	<i>October 1, 2026</i>	New section
Sec. 11	<i>October 1, 2026</i>	New section
Sec. 12	<i>from passage</i>	New section
Sec. 13	<i>from passage</i>	New section
Sec. 14	<i>from passage</i>	New section
Sec. 15	<i>from passage</i>	New section
Sec. 16	<i>from passage</i>	New section
Sec. 17	<i>July 1, 2026</i>	New section
Sec. 18	<i>January 1, 2027</i>	38a-591d
Sec. 19	<i>October 1, 2026</i>	17b-238(b)
Sec. 20	<i>January 1, 2027</i>	17b-238(b)
Sec. 21	<i>January 1, 2027</i>	38a-591c(a)(2)(C)
Sec. 22	<i>January 1, 2027</i>	38a-591n(a)(1)

Statement of Legislative Commissioners:

In Section 1(e), "health program" was changed to "health care program" for consistency; in Section 4(b) "program" was changed to "Connecticut Option program" for clarity; in Section 4(e), the last sentence was redrafted for clarity; in Section 5(f), the last sentence was redrafted for clarity; in Section 6, the effective date was changed for accuracy; in Sections 7 and 12, references to "cochairperson" and "cochairpersons" were changed to "chairperson" and "chairpersons" for clarity and consistency; in Section 7(b)(8), "along with the Secretary of the Office of Policy and Management, or the secretary's designee," was added for clarity; in Section 9(d)(1) and 9(d)(2), "that were rendered to a deceased spouse" was deleted for clarity; Section 10(b)(2) and 10(c) were redrafted for clarity; in Section 11(c), "17b-60" was changed to "17b-238" for accuracy; in Section 12(c)(3), "federal action" was changed to "changes" for consistency; in Section 13(2), "the programs" was changed to the

"supplemental nutrition assistance and Medicaid programs" for clarity; in Section 14(b), "requirements or administrative operations of" was changed to "requirements for or administrative operations of" for clarity; in Section 15(a)(2), "where" was changed to "when" for clarity; Section 15(e) was redrafted for clarity; Section 15(h) was redrafted for clarity; and Sections 19, 20, 21 and 22 were added for accuracy and statutory consistency.

HS *Joint Favorable Subst. -LCO*

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:

Agency Affected	Fund-Effect	FY 27 \$	FY 28 \$
Resources of the CAHCT Fund	CAHCT Fund - See Below	See Below	See Below
Resources of the Federal Cuts Response Fund	SF - Transfer from	200 million	None
Resources of the CAHCT Fund	SF - Transfer to	200 million	None
Policy & Mgmt., Off.	GF - Cost	765,200	260,940
Social Services, Dept.	GF - Potential Cost	See Below	See Below
State Comptroller - Fringe Benefits ¹	GF - Cost	108,730	108,730
State Comptroller - Fringe Benefits	Various - Potential Cost	Significant	Significant
UConn Health Ctr.	OF - Potential Revenue Gain	See Below	See Below
Social Services, Dept.	GF - Cost	See Below	See Below

Note: CAHCT Fund = Connecticut Affordable Health Care Trust Fund; SF=Special Fund (Non-appropriated); GF=General Fund; Various=Various

Municipal Impact:

Municipalities	Effect	FY 27 \$	FY 28 \$
Various Municipalities	Potential Cost	Significant	Significant

Explanation

Sections 1-4 create and fund the Connecticut Affordable Health Care Trust (CAHCT) fund to, in part, support the design and implementation

¹The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.82% of payroll in FY 27.

of a Connecticut Option healthcare program.

Revenues of the CAHCT Fund

Section 3 requires the Office of Policy and Management (OPM) to transfer \$200 million from the Federal Cuts Response Fund to the CAHCT Fund in FY 27.

The bill also requires the resources of the CAHCT fund be invested by the Treasurer separate and apart from other state investments, but in the same manner as several other state investment funds. Investment revenues are indeterminate, as they are dependent on available resources, market returns, and future investment decisions.

Expenses of the CAHCT Fund

To the extent amounts on deposit in the fund meets or exceeds the amount needed to fund the program, there will be ongoing annual administrative and investment costs associated with the CAHCT fund as a result of the bill starting no earlier than FY 27. Administrative expenses include a one-time cost to the State Treasurer associated with the establishment of the CAHCT fund of up to \$100,000. The bill allows the CAHCT fund to enter into contracts for various administrative, legal, and investment services. The bill specifies the ongoing costs of administering the CAHCT Fund are to be covered by the resources of the fund. As such, there is not anticipated to be a cost to appropriated funds or municipalities due to these sections.

Section 4 establishes a Connecticut Option affordable health care program within OPM. This results in a cost of \$500,000 in FY 27 to OPM for a consultant to develop the health care program.

There is also a cost of \$132,600 in FY 27 and an annual cost of \$130,470 beginning in FY 28 to OPM and corresponding fringe benefit costs beginning in FY 27 to the Office of the State Comptroller for a Policy Development Coordinator position. This position will support an annual reporting requirement in the bill beginning January 1, 2027, work with the consultant in the design and development of the health

care program and serve as the OPM designee for a working group established in section 7 of the bill.

Sections 5 and 6 result in a cost to the Department of Social Services (DSS) associated with establishing a basic health program, which is guided by the recommendations of the working group established in section 7. While the impact of implementing such a program is unknown at this time and dependent on how the program is ultimately structured, DSS will incur initial contracting costs of \$750,000 to develop and submit the required waiver as well as costs for additional staff and resources to perform an actuarial analysis, procure a managed care organization, and set up other potentially necessary operational mechanisms to implement the program.

Section 7 establishes a working group within OPM to design the Connecticut Option program established in section 4 of the bill. These requirements outlined in the section contribute to the cost to OPM in section 4 for a Policy Development Coordinator position.

Section 8 requires OPM to hold public hearings and stakeholder engagement meetings. This results in a cost to OPM beginning in FY 27 to hold each of these meetings. This cost is dependent on the number of meetings held and the cost associated with each meeting.

Section 10 results in a potential revenue gain to the UConn Health Center (UHC) annually beginning in FY 27. It allows any hospital, including UHC, to participate in a financial assistance program established by the bill for patients who meet certain income and other criteria. Presumably, UHC would only choose to participate if the program increased net patient revenue, and the bill's reimbursement from DSS offset the cost of participating in this program. Any revenue gain would depend on: (1) the number of qualifying patients who participate; and (2) how the program's changes in qualifying patient payments compare to the reimbursement UHC would receive from DSS.

In the past 12 months, UConn Health has served at least 5,299

uninsured patients and 749 insured patients who met the bill's income parameters.² On average, the uninsured patients who met the bill's income parameters owed \$810 out-of-pocket, and they ultimately paid 63% to 72% of that amount (i.e., \$227 to \$300 is left unpaid). The insured patients owed \$301, and they ultimately paid 69% to 81% of that amount (i.e., \$57 to \$93 left unpaid).

Section 11 results in a Medicaid cost to DSS associated with disproportionate share hospital payments (DSH). The bill requires DSS to make DSH payments to hospitals as compensation for participating in the hospital financial assistance program established by the bill, using criteria to be identified by DSS. The extent of the cost to DSS is unknown and will be based on participating hospitals, criteria developed, and relevant costs. For context, DSH payments must meet federal requirements in order for states to receive a 50% federal share and are subject to both hospital and state specific limits.

Section 12 establishes a safety net mitigation working group within OPM to advise the state's response to significant changes in federal law or policy that impact certain program and requires the group to report annually beginning February 1, 2027. This results in a cost of \$132,600 in FY 27 and an annual cost of \$130,470 beginning in FY 28 to OPM and corresponding fringe benefit costs beginning in FY 27 to the Office of the State Comptroller for a Policy Development Coordinator position. This position will also be responsible for requirements outlined in section 14 of the bill.

Section 14 requires OPM to notify the certain committees on federal statutes, regulations, rules, or administrative guidance that is likely to impact federal health funding levels and provide recommendations. This results in a cost to OPM for a Policy Development Coordinator

² These numbers represent the number of insured and uninsured patients at UCHC who have applied for financial assistance in the past 12 months and otherwise meet the bill's eligibility parameters. These figures do not include patients who may be eligible to participate in the bill's financial assistance program due to participation in SNAP or WIC.

position that is outlined in section 12.

Section 15 results in a potential cost to DSS to establish a program for collecting information from employers or other entities to support Medicaid and SNAP eligibility determinations. To the extent DSS establishes a program outside of the current scope of practice, DSS may incur system modification costs to support the new program.

Section 17 requires DSS to submit any proposal to change the fee-for-service Medicaid payment model to a managed care payment model to the Appropriations and Human Services committees before implementing or seeking any necessary federal approval to implement such change. To the extent this delays or prevents a change that otherwise would have occurred, the state could experience a fiscal impact that cannot be determined at this time.

Section 18 shortens the timeframe for prior authorization and deems requests approved if health carriers fail to meet these standards. The state and fully insured municipalities may experience significant cost increases in medical and pharmacy spend beginning in FY 27 if the changes outlined in the bill result in greater number of authorizations deemed approved. The state plan currently saves approximately \$84 million annually under current prior authorization procedures.

Sections 19 and 20 result in potential increased administrative costs to DSS to the extent participating hospitals utilize the appeals process authorized by the bill as referenced in Section 11.

The bill makes other clarifying, conforming and technical changes that do not result in a fiscal impact.

The Out Years

The annualized ongoing fiscal impact will continue into the future subject to inflation, the allowable scope of DSH payments, and any future changes to the Medicaid payment model.

OLR Bill Analysis**sSB 3*****AN ACT CONCERNING HEALTH CARE AFFORDABILITY.***

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Requires OPM to hold at least one public hearing and a series of stakeholder engagement meetings before each program's implementation

§ 9 — SPOUSAL MEDICAL DEBT

Prevents surviving spouses from being liable for certain medical debt of a deceased spouse

§§ 10, 11, 19 & 20 — HOSPITAL FINANCIAL ASSISTANCE PROGRAM

Establishes a voluntary hospital financial assistance program, sets requirements for the program, and authorizes hospitals to be reimbursed through DSH payments

§ 12 — SAFETY NET MITIGATION WORKING GROUP

Establishes a safety net mitigation working group and requires it to report annually to the Appropriations, Human Services, Housing, and Insurance and Real Estate committees

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Requires DSS to report monthly on implementation and effects of federal work and community engagement requirements in Medicaid and SNAP

§ 14 — OPM NOTICE TO LEGISLATORS ON HUSKY HEALTH AND SNAP

Requires the OPM secretary to notify and make recommendations to the Appropriations and Human Services committees when he determines federal changes may affect SNAP or HUSKY Health and allows the committees to hold a public hearing

§ 15 — DSS DATA ACCESS AND EMPLOYMENT VERIFICATION

Requires DSS to have access to data from other state agencies to verify SNAP work requirements and Medicaid community engagement requirements and sets related requirements; allows DSS to establish a program to facilitate enrollment and automatic eligibility renewal for Medicaid or SNAP

§ 16 — “MEDICAL FRAILTY” DEFINITION

Requires DSS to develop a state definition of “medical frailty” and report the proposed definition to the Human Services Committee within 60 days after the bill passes

§ 17 — LEGISLATIVE REVIEW OF MEDICAID PAYMENT MODEL CHANGES

Requires DSS to submit to the Appropriations and Human Services committees any proposal to change the Medicaid payment model from fee-for-service to managed care

§§ 18, 21 & 22 — UTILIZATION REVIEW REQUESTS AND PRIOR AUTHORIZATION

Shortens maximum response times for decisions on non-urgent prospective or concurrent review requests; establishes deadlines and related requirements for prior authorization determinations for urgent and non-urgent care requests and deems prior authorization requests approved if health carriers fail to act within set time frames; makes prior authorization approval a binding payment and coverage determination

SUMMARY

This bill establishes new health care programs, trust funds, and working groups, and a makes other changes in laws related to health care, Medicaid, and other programs, as described in the section-by-section analysis below. It also makes technical and conforming changes.

EFFECTIVE DATE: Various, see below.

§§ 1-3 — CONNECTICUT AFFORDABLE HEALTH CARE TRUST FUND

Creates the Connecticut Affordable Health Care Trust Fund to fund the Connecticut Option (see § 4) and transfers \$200 million to it from the Federal Cuts Response Fund

The bill establishes the Connecticut Affordable Health Care Trust Fund and requires that it be used to implement the Connecticut Option affordable health care program (see § 4). The bill requires the Office of Policy and Management (OPM) to transfer \$200 million to the trust fund from the Federal Cuts Response Fund for FY 27.

The bill authorizes it to hold all payments and contributed deposits; gifts; bequests; endowments; federal, state, or local grants; and any other funds from any public or private source and all earnings until they are disbursed. The trust exists as long as it has deposits or obligations and until terminated by law.

Funds in the trust are not state property; they cannot be combined with state funds and the state has no claim on them. Similarly, contracts and obligations associated with the trust are not state debts or obligations. Under the bill, the state has no obligation to any person on

account of the trust. Also, amounts obligated to be paid from the trust are limited to what is deposited in it.

Regardless of existing law's requirements for the treasurer on investments of the state's trust funds, the bill requires the treasurer to (1) invest funds in the trust in a reasonable and appropriate way to achieve the fund's objectives, using a similarly situated prudent person's discretion and care and (2) duly consider the rate of return, risk, term or maturity, diversification of the fund's total portfolio, liquidity, projected disbursements and expenditures, and expected payments, deposits, contributions, and future gifts.

The bill prohibits the treasurer from requiring the fund to invest directly in state or political subdivision obligations or in any investment or other endowment the treasurer administers. It requires the fund's assets to be continuously invested and reinvested, consistent with its objectives, until expended.

It otherwise extends to the fund the same requirements that state law sets for other state trust funds, including the Teachers' Pension Fund, the State Employees Retirement Fund, and the Connecticut Municipal Employees' Retirement Fund.

The bill requires the treasurer to ensure that sufficient liquidity exists within the fund to allow for expenditures in each fiscal year. It allows him, on the fund's behalf, to:

1. receive and invest money in the fund in any instruments, obligations, securities, or property;
2. enter into contracts for services for the fund (such as legal, actuarial, accounting, advisory, and management) and pay for services from the fund's assets;
3. obtain insurance in connection with the fund's property, assets, activities, or deposits;
4. apply for and accept gifts, grants, or donations;

5. adopt regulations;
6. sue and be sued;
7. establish accounts within the fund; and
8. take any other action needed to carry out the bill's purposes and related to the bill's duties for the treasurer.

EFFECTIVE DATE: July 1, 2026

§ 4 — CONNECTICUT OPTION AFFORDABLE HEALTH CARE PROGRAM

Establishes the Connecticut Option program within OPM for affordable health insurance coverage; requires it to provide premium subsidies until December 31, 2027, for QHPs for households with certain incomes who are ineligible for Covered Connecticut or who are ineligible for ACA subsidies; allows the program to include other plans and subsidy options

The bill establishes the Connecticut Option affordable health care program within OPM to create affordable health insurance coverage. Under the bill, an affordable health plan is a qualified health plan (QHP) with premiums that cost (1) up to 2% of household income for people with household income up to 200% of the federal poverty level (FPL) and (2) up to 8.5% of household income for people with household income of at least 400% of FPL.

EFFECTIVE DATE: Upon passage

Program Benefits and Eligibility

Under the bill, the Connecticut Option program includes a state health care premium subsidy to enable an eligible enrollee to get an affordable health plan on Access Health CT from July 1, 2026, to December 31, 2027. Eligible enrollees are state residents who are eligible for a QHP through Access Health CT and have (1) household income up to 200% of FPL but are ineligible for the Covered Connecticut program or (2) household income above 400% but not more than 600% of FPL but are ineligible for premium subsidies under the federal Affordable Care Act (ACA).

The bill additionally allows the program to include (1) a buy-in option for a health plan that mirrors Medicaid and (2) other options for subsidies for eligible enrollees or other people to buy affordable health plans.

The bill allows the program to include additional affordable health care options for people at all income levels. It may promote these options by authorizing a primary insurer to transfer portions of its risk portfolios to another entity to limit maximum losses and stabilize financial performance.

Program Design and Implementation

The bill requires the OPM secretary to design and implement the program:

1. in consultation with the Department of Social Services (DSS) commissioner, the Connecticut Insurance Department (CID) commissioner, and the Access Health CT chief executive officer;
2. using money from the Connecticut Affordable Health Care Trust Fund (see above) and other available funding sources; and
3. subject to recommendations from a working group the bill establishes (see § 7).

The bill requires OPM to adopt the working group's recommendations based on:

1. affordability analyses,
2. projected impact on the rates of uninsured people,
3. protection against adverse selection,
4. benefit comprehensiveness, and
5. impact on equitable access to health care and sustainability.

The bill authorizes the OPM secretary to:

1. solicit economic analysis of key policy options for affordable health insurance (for example, plans mirroring Medicaid, QHPs, or the state employee health plan), which may include policies to promote cost containment and network adequacy and mitigate impacts on the individual health insurance market;
2. accept gifts, grants, and donations, which must be deposited in the Connecticut Affordable Health Care Trust Fund (see above) and use any other available state or federal funds;
3. employ or contract with actuaries and other professionals; and
4. contract with other state agencies, health carriers, or other qualified people and entities as needed.

Reporting Requirement

The bill requires OPM to report to the Appropriations, Human Services, and Insurance and Real Estate committees on the Connecticut Option program's operations, activities, and finances, and include any supporting documentation or data. The report must be submitted by January 1, 2027, then every six months until January 1, 2030, and annually after that.

Background — Related Bills

sHB 5041, favorably reported by the Human Services Committee, and sHB 5378, favorably reported by the Insurance and Real Estate Committee, require OPM to study the feasibility of establishing a Connecticut Option program.

§§ 5 & 6 — BASIC HEALTH PROGRAM

Requires DSS to establish a BHP to provide subsidized health insurance to eligible individuals with certain household incomes who are not eligible for state medical assistance but are eligible to buy QHPs through Access Health CT

Starting October 1, 2026, the bill requires DSS, in consultation with OPM and based on recommendations from a working group the bill establishes (see § 7), to seek any necessary approvals from the federal government to establish a basic health program (BHP, see *Background – BHP*) and take all necessary actions to maximize federal funding. (The

working group's report is not due until December 1, 2026.)

EFFECTIVE DATE: Upon passage, except the provision establishing the account is effective July 1, 2026.

Program Administration and Benefits

The bill requires the DSS commissioner to coordinate the BHP's administration and benefits. To the extent the ACA allows, it requires the BHP to provide the same benefits, cost-sharing limits, and other consumer safeguards that apply in the state's medical assistance programs (generally Medicaid or HUSKY Health).

The bill allows the DSS commissioner, in consultation with OPM, to develop a plan to respond if she determines that:

1. providing medical assistance to eligible individuals under the BHP will cost more than the federal subsidies available to the state to pay for the BHP or
2. changes in federal law or regulations (or their administration) will affect BHP funding, eligibility requirements, or administration.

Under the bill, if the federal subsidies the state receives to pay for the BHP exceed the cost of care that would otherwise be provided to eligible individuals, the commissioner must use them to reduce these individuals' premiums and cost sharing or provide additional benefits.

Eligibility Requirements

Under the bill, the BHP provides subsidized health insurance to Connecticut residents (1) with household incomes above 133% but no more than 200% of the FPL; (2) under age 65; (3) ineligible for state medical assistance programs (for example, Medicaid); and (4) otherwise eligible to buy a QHP through Access Health CT.

BHP Account

The bill establishes a separate, nonlapsing BHP account, which contains any moneys required by law to be deposited into it (for

example, federal subsidies) and DSS must use the funds solely to operate the program.

Federal Applications and Reporting Requirement

The bill requires the DSS commissioner to forward any application for federal approval of, or changes to, a BHP to the Appropriations and Human Services committees and the working group the bill establishes (see § 7) at least 30 days before doing so.

Under the bill, the DSS commissioner must report to the Appropriations, Human Services, and Insurance and Real Estate committees on the BHP's operations, activities, and finances, as well as any supporting documentation or data, for the immediately preceding reporting period. The commissioner must submit the reports (1) every six months, starting by January 1, 2027, and through January 1, 2030, and (2) annually after that.

Background — BHP

The ACA allows states to establish BHPs for people (1) ineligible for Medicaid; (2) under age 65; (3) with household income between 133% and 200% of the FPL (individuals with incomes under 133% of the FPL qualify for Medicaid); and (4) ineligible for minimal essential health care coverage (for example, State Children's Health Insurance Program (HUSKY B in Connecticut)) or who cannot afford their employer's coverage.

The federal law has cost-sharing limits and requires that state BHPs provide benefits at least as robust as those in the state's "essential health benefits package" available to someone buying insurance through its health insurance exchange.

States that operate a BHP are eligible for federal subsidies equaling 95% of the premium tax credits and cost-sharing reductions that the federal government would have spent if BHP enrollees had received their assistance when enrolling in an exchange health plan.

The law requires states to establish funds into which the federal

subsidies are deposited and can be used only to reduce BHP enrollees' premiums and cost sharing or to give them additional benefits (42 U.S.C. § 18051).

Background — Related Bill

sHB 5559, favorably reported by the Human Services Committee, similarly requires DSS to establish a BHP.

§ 7 — CONNECTICUT OPTION AND BHP WORKING GROUP

Establishes a working group to oversee design of the Connecticut Option program and BHP and requires it to report recommendations for these programs by December 1, 2026

The bill requires the OPM secretary to establish a working group to oversee the design of the bill's Connecticut Option program (§ 4) and BHP (§§ 5 & 6). It authorizes the working group to consult with stakeholders, including Access Health CT enrollees, health care providers, health insurance issuers, health care advocates, researchers, actuaries, and nonprofit health care service providers.

EFFECTIVE DATE: Upon passage

Connecticut Option and BHP Recommendations

The bill requires the working group to report to the Appropriations, Human Services, and Insurance and Real Estate committees by December 1, 2026, on its recommendations for the design and implementation of the Connecticut Option and BHP. The submitted report must describe the programs, including their operation and funding.

Working Group Members and Structure

The bill designates the following, or their designees, as working group members:

1. Connecticut healthcare advocate;
2. CID and DSS commissioners and the OPM Secretary;
3. Commission on Racial Equity and Public Health executive director;

4. state comptroller;
5. the six legislative leaders;
6. chairpersons of the Insurance and Real Estate Committee; and
7. Access Health CT chief executive officer.

The working group must also have the chairpersons of the Human Services Committee and three health insurance experts from nonprofit and academic communities with demonstrated knowledge about health plan design and actuarial practices. The working group's chairpersons (the OPM secretary and the Human Services Committee chairpersons) appoint the health insurance experts. The bill also allows them to appoint any other members they deem necessary.

Under the bill, members appointed by the legislative leaders and the appointed experts may be legislators. They serve at the pleasure of the appointing authority and continue to serve until their successors are appointed. Appointing authorities fill any vacancies.

The bill requires all initial appointments to be made by 30 days after the bill passes. If they are not done by this time, the bill allows the OPM secretary to designate people with the required qualifications to serve on the working group until the appointments are made.

Under the bill, a majority of working group members is a quorum to transact business and the working group makes decisions by majority vote of members present at a meeting, except that the co-chairpersons can establish committees, sub-committees, or other entities as they deem necessary to further the working group's purposes. The bill allows the working group to adopt rules of procedure.

Working group members serve without pay but must be reimbursed for expenses necessary in performing their duties, within available funds and subject to the working group co-chairpersons' approval.

§ 8 — CONNECTICUT OPTION PROGRAM AND BHP PUBLIC HEARINGS AND STAKEHOLDER MEETINGS

Requires OPM to hold at least one public hearing and a series of stakeholder engagement meetings before each program's implementation

The bill sets public hearing and stakeholder meeting requirements for the Connecticut Option and the BHP. For each program, it requires the OPM secretary to hold at least one public hearing and a series of stakeholder engagement meetings with potential stakeholders before they are implemented. Under the bill, the stakeholders include:

1. hospital, health center, and other health care provider representatives;
2. HUSKY Health plan enrollees and Access Health CT enrollees;
3. legislators on the Appropriations, Human Services, Public Health, and Insurance and Real Estate committees; and
4. other people with health equity and health coverage policy expertise.

EFFECTIVE DATE: July 1, 2026

§ 9 — SPOUSAL MEDICAL DEBT

Prevents surviving spouses from being liable for certain medical debt of a deceased spouse

Current law generally makes it the joint duty of each spouse to support their family, and makes them both liable for certain expenses, including rent and certain medical expenses. The bill creates an exception to this liability. Specifically, it prohibits a surviving spouse from being liable for a deceased spouse's medical debt that is (1) not covered by the deceased spouse's estate and (2) related to hospital expenses or reasonable and necessary physician or dentist services.

EFFECTIVE DATE: July 1, 2026

§§ 10, 11, 19 & 20 — HOSPITAL FINANCIAL ASSISTANCE PROGRAM

Establishes a voluntary hospital financial assistance program, sets requirements for the program, and authorizes hospitals to be reimbursed through DSH payments

The bill establishes a voluntary hospital financial assistance program that requires participating hospitals to provide financial assistance to

patients, if they meet specified income thresholds and, in some cases, are enrolled in certain federal nutrition assistance programs. The financial assistance, which may include a hospital bed fund, must partially or totally reduce a patient's liability for the cost of care. (Generally, a hospital bed fund refers to donations of money, stock, or other property to a hospital to give free patient care.)

The bill sets related eligibility and care requirements for participating hospitals and authorizes them to be reimbursed by disproportionate share hospital (DSH) payments, which are Medicaid payments to hospitals that serve a disproportionately large number of Medicaid and uninsured patients.

Correspondingly, the bill requires the DSS commissioner to (1) amend the Medicaid state plan to use DSH payments to compensate participating hospitals and (2) set criteria for them to document the financial assistance they provide and be timely paid for it.

Under the bill, a hospital aggrieved by the commissioner's final decision on the validity of its bills for financial assistance may request a rehearing using the existing process for DSS payment rates and audits. Under this process, hospitals may appeal any items not resolved at a rehearing to the Superior Court, as authorized under the Uniform Administrative Procedure Act.

EFFECTIVE DATE: October 1, 2026

Care Requirements

Under the bill, hospitals that choose to participate in the bill's hospital financial assistance program must provide inpatient and outpatient care as follows:

1. for free to uninsured patients with income up to 200% of the FPL;
2. subsidized care to uninsured patients with income between 201% and 300% FPL; and
3. subsidized care for patients with income up to 400% FPL who are

enrolled in the federal Supplemental Nutrition Assistance Program (SNAP) or Special Supplemental Food Program for Women, Infants, and Children (WIC).

For patients with incomes under 200% FPL who are ineligible for financial assistance, the bill requires participating hospitals to bill them on a payment plan that is 2% or less of their annual household income per year. After 36 cumulative payments, hospitals must consider these patients' bills paid in full and permanently stop collection activities on any remaining balance.

Eligibility Requirements

The bill prohibits participating hospitals from (1) counting a patient's assets when determining program eligibility or (2) requiring a patient to provide proof of a denial letter from a public insurance program (state medical assistance programs (for example, Medicaid), Emergency Medicaid, and Medicare), or insurance through Access Health CT.

Hospitals must use software that conforms to industry standards on electronic income verification and may accept one of the following documents to verify a patient's income:

1. a copy of the patient's most recent tax return or W-2 and 1099 forms,
2. copies of the patient's two most recent pay stubs, and
3. an employer's written income verification if the patient is paid in cash.

The bill exempts from these income verification requirements patients who are experiencing (or are at imminent risk of) homelessness but allows hospitals to require them to give self-attested information for a program screening or application.

Program Information in Other Languages

Regardless of the state's law on hospital bed funds (see *Background – Hospital Bed Fund Patient Summaries*), the bill requires participating

hospitals to make available financial assistance program information in the languages spoken by 5% or more of the population living in the geographic area the hospital serves.

Under the bill, the information must (1) be in all discharge paperwork and on the hospital's website; (2) have the Office of the Health Care Advocate's contact information; and (3) comply with the federal Americans with Disabilities Act requirements for effective communication (providing free auxiliary aids and services, such as braille, large print, and relay services).

Background — Hospital Bed Fund Patient Summaries

Existing law requires each hospital that maintains or administers bed funds to make available to patients a one-page plain language summary in English and Spanish on its financial assistance policy.

Background — Related Bill

sSB 496, favorably reported by the Human Services Committee, also establishes a voluntary hospital financial assistance program.

§ 12 — SAFETY NET MITIGATION WORKING GROUP

Establishes a safety net mitigation working group and requires it to report annually to the Appropriations, Human Services, Housing, and Insurance and Real Estate committees

The bill establishes a safety net mitigation working group to advise on, monitor, and coordinate the state's response to significant changes in federal law or policy that impact public health, social services, or other safety net programs.

Working Group Membership

The bill designates the following, or their designees, as working group members:

1. OPM secretary;
2. DSS, Department of Revenue Services, Department of Mental Health and Addiction Services, Department of Developmental Services, Department of Public Health (DPH), Insurance

Department, and Department of Labor (DOL) commissioners;
and

3. chairpersons of the Appropriations, Housing, Human Services, and Insurance and Real Estate committees, who must jointly choose the working group's chairpersons.

The working group also includes (1) the Access Health CT chief executive officer, (2) the Commission on Racial Equity in Public Health executive director, (3) three subject matter experts jointly appointed by the working group's chairpersons, and (4) any other members the chairpersons deem necessary.

Under the bill, the experts are one for each of the following subjects: (1) health and human services policy administration, (2) data science, analytics, or interagency data integration; and (3) user experience or person-centered design. Appointed members serve at the pleasure of the chairpersons.

Working Group Duties

Under the bill, the working group must convene within 30 days after the bill passes and has the following duties:

1. review any significant changes in federal law or policy impacting public health, social services, or other safety net programs;
2. evaluate the current or projected operational and fiscal impacts of these changes on agency procurement and service delivery;
3. recommend budgetary, regulatory, administrative, or legislative measures to mitigate adverse procurement or service outcomes to OPM and the Appropriations, Housing, Human Services, and Insurance and Real Estate committees; and
4. solicit input from stakeholders, including municipal governments, community-based providers, and independent experts (such as academic researchers and policy organizations) as necessary.

Annual Report

The bill requires the working group to report annually, starting by February 1, 2027, to the Appropriations, Housing, Human Services, and Insurance and Real Estate committees. The report must include:

1. the estimated number and percentage of Medicaid and SNAP beneficiaries who may qualify for exemptions from work or community engagement requirements in two specified recent federal laws (P.L. 118-5 and P.L. 119-21 both expand these requirements);
2. a review of current state and federal data systems used to verify whether someone qualifies for an exemption from these requirements due to disability or other allowable criteria or has met them;
3. a review of any state applications for the Rural Health Transformation Program or federal technical assistance funding; and
4. recommendations for creating a structured and sustainable system to support interagency data sharing, beneficiary identification, and administrative practices that maximize allowable federal exemptions.

EFFECTIVE DATE: Upon passage

§ 13 — MONTHLY DSS REPORTS ON WORK AND COMMUNITY ENGAGEMENT REQUIREMENTS

Requires DSS to report monthly on implementation and effects of federal work and community engagement requirements in Medicaid and SNAP

The bill requires the DSS commissioner to report monthly to the Human Services Committee on implementation and effects of federal work and community engagement requirements in Medicaid and SNAP. The commissioner must do this in consultation with the DOL commissioner and start the reporting 30 days after the bill passes.

Specifically, the bill requires DSS to report on the following:

1. implementation of federal law on work and community engagement requirements for Medicaid and SNAP under P.L. 119-21;
2. the number of beneficiaries who lost or are expected to lose eligibility for SNAP and Medicaid since implementing requirements;
3. copies of any documentation or reporting given to the federal government related to these requirements;
4. a list of changes to contracts with existing vendors and requests for proposals for new vendors related to these requirements;
5. a list of data sources being used for automatic verification of work or income status or qualifications for exemptions from the requirements;
6. records related to how (a) DSS will define “medical frailty” for potential exemptions (see § 16) and (b) compliance verification will be streamlined for SNAP and Medicaid recipients;
7. a summary of how SNAP and Medicaid recipients will be engaged in the decision-making process;
8. a long-term plan for ongoing information sharing and support for Medicaid and SNAP recipients and providers to minimize disenrollment of eligible individuals; and
9. statistics on DSS’s customer service telephone call center, including average response time to calls, call abandonment rate, level of staff attrition, and details on new staff hired in the past fiscal year.

EFFECTIVE DATE: Upon passage

§ 14 — OPM NOTICE TO LEGISLATORS ON HUSKY HEALTH AND SNAP

Requires the OPM secretary to notify and make recommendations to the Appropriations and Human Services committees when he determines federal changes may affect SNAP or HUSKY Health and allows the committees to hold a public hearing

The bill requires the OPM secretary to notify the Appropriations and Human Services committees in writing whenever he determines that a federal statute, regulation, rule, or administrative guidance is likely to significantly affect SNAP or HUSKY Health federal funding levels, program enrollment, eligibility requirements, or administrative operations. HUSKY Health includes Medicaid and the State Children's Health Insurance Program, along with any related federally-approved state plan amendments or waivers.

The OPM secretary must make this determination in consultation with the DSS commissioner. The notice must include recommendations on state statutes or regulations that may need changes to preserve access to these programs and maximize the number of people eligible for them.

The bill allows the Appropriations and Human Services committees to hold a public hearing within 14 days after receiving OPM's notice and recommendations.

EFFECTIVE DATE: Upon passage

§ 15 — DSS DATA ACCESS AND EMPLOYMENT VERIFICATION

Requires DSS to have access to data from other state agencies to verify SNAP work requirements and Medicaid community engagement requirements and sets related requirements; allows DSS to establish a program to facilitate enrollment and automatic eligibility renewal for Medicaid or SNAP

The bill requires DSS to receive or have access to data kept by other agencies (such as DOL, DPH, the Department of Education (SDE), and the Office of Higher Education (OHE)) to administer public assistance programs (for example, HUSKY Health and SNAP). (The bill also limits data use to SNAP work requirement and Medicaid community engagement activities, see below.)

EFFECTIVE DATE: Upon passage

Data Uses

The bill authorizes DSS to use the data for the following purposes:

1. determining if someone qualifies for an exemption from SNAP work requirements or Medicaid community engagement requirements;
2. verifying compliance with applicable work or community engagement requirements;
3. identifying and implementing any other uses of interagency data that facilitate effective program administration; and
4. identifying and implementing more uses of interagency data to streamline eligibility and the enrollment process, with the goal of minimizing reductions in each that might result from changes in federal law.

Types of Data

Under the bill, data accessible to DSS must at least include the following:

1. DOL employment and wage records;
2. DPH vital records, including birth, death, guardianship, and dependency records;
3. SDE or OHE records of school enrollment and attendance from secondary and postsecondary educational institutions; and
4. any other data kept by a state agency that DSS determines is needed to verify federal exemption eligibility criteria.

Limits on Data Use

The bill restricts DSS' use of data received under these provisions to the following purposes:

1. identifying and verifying if someone qualifies for an exemption from SNAP work requirements or Medicaid community engagement requirements and
2. determining if someone has met work or community

engagement requirements to facilitate enrollment and automatic eligibility renewal.

The bill also prohibits DSS from disclosing this data except as otherwise authorized by state or federal law.

Employment Verification Systems and Programs

To the extent allowed by federal law, the bill authorizes DSS to do the following:

1. verify Medicaid and SNAP enrollees' employment and community engagement status using self-attestation and waive requirements for enrollees with medical frailty (see § 16);
2. establish a system for HUSKY Health and SNAP applicants and enrollees to consent to DSS for it to access and use data kept by other agencies to determine or renew eligibility; and
3. within available appropriations, set up a program to facilitate enrollment and automatic eligibility renewal for Medicaid or SNAP by accepting information from employers, nonprofits, and other organizations on behalf of their employees, clients, volunteers, or other parties to verify compliance with work or community engagement requirements.

Interagency Data-Sharing Agreements

The bill requires DSS to enter into interagency data-sharing agreements with each agency from which it accesses or receives data for these purposes. The agreements must specify data categories to be shared, the data's purpose and ways it will be used, procedures to ensure data security and compliance with applicable privacy laws, and limits on further data use or disclosure.

Data Disclosure Notice

The bill requires DSS to notify the Human Services Committee in writing before disclosing any data under these provisions and include in the notice where it intends to send data and the legal authority for

doing so.

Confidentiality, Privacy, and Security Laws

The bill requires data use and data-sharing activities to comply with all applicable state and federal laws on confidentiality, privacy, and security, including:

1. the federal Health Insurance Portability and Accountability Act (HIPAA) and the federal Family Educational Rights and Privacy Act (FERPA),
2. federal regulations on disclosing substance use disorder patient records,
3. state laws limiting disclosure of DSS program participant information, and
4. state laws on state agency data sharing.

§ 16 — “MEDICAL FRAILTY” DEFINITION

Requires DSS to develop a state definition of “medical frailty” and report the proposed definition to the Human Services Committee within 60 days after the bill passes

The bill requires the DSS commissioner to develop a state definition of “medical frailty” in advance of new federal guidance on using a medical frailty classification for exemptions from SNAP work requirements and Medicaid community engagement requirements.

To do this, the bill requires the commissioner to consider:

1. existing definitions in state statutes and regulations for similar physical conditions;
2. medical frailty definitions in other states;
3. related medical codes for diagnosing a medical frailty classification; and
4. ways to streamline the classification across DSS-administered programs that enroll medically frail people (presumably, after

the definition of this term is developed).

The bill requires the DSS commissioner to file a report to the Human Services Committee on its proposed definition within 60 days after the bill passes.

EFFECTIVE DATE: Upon passage

§ 17 — LEGISLATIVE REVIEW OF MEDICAID PAYMENT MODEL CHANGES

Requires DSS to submit to the Appropriations and Human Services committees any proposal to change the Medicaid payment model from fee-for-service to managed care

The bill establishes a legislative approval process for proposals to change the Medicaid payment model from fee-for-service to managed care (see *Background – Managed Care and Fee-for-Service Payment Models*).

Comment Period and Hearing

Under the bill, DSS must submit the proposal, including any written comments the department receives on it, to the Appropriations and Human Services committees. The bill requires DSS to accept written comments on the proposal before submitting it to the committees. The department must post notice of the proposal, with a summary of its provisions and how to submit comments, 30 days before submitting it to the committees. The committees must:

1. hold a public hearing within 30 days after they receive the proposal;
2. notify the DSS commissioner about the hearing's date and time at least 15 days before it; and
3. invite her to testify, including about any costs or benefits to the state and expected impacts on care provided to Medicaid recipients and Medicaid provider payments.

At the end of the hearing, the committees must vote on whether to approve, deny, or modify the proposal and advise the commissioner of their decision. The bill prohibits the commissioner from implementing

or seeking federal approval to implement a denied proposal.

Conference Committee

If the Appropriations and Human Services committees do not agree on a proposal, the bill requires committee chairpersons to appoint a conference committee, made up of three members of each committee, with at least one member from the minority party from each committee. The conference committee must report to each committee, which must vote to accept or reject the conference committee's report without amendment. If either committee rejects the report, the proposal is deemed denied. If they both accept it, the Appropriations Committee must advise the DSS commissioner of the approval, denial, or modifications to the proposal.

Proposals Deemed Denied

If the committees do not advise the commissioner during the 30-day period (presumably, the 30-day period after the committees receive the proposal), the proposal is deemed denied.

Implementation Application

The bill requires any application for a Medicaid state plan amendment, federal waiver, or waiver renewal to implement a proposal to align with the Appropriations and Human Services committees' approval or modifications. It also requires DSS to include with the application any written comments it received during the comment period and at the hearing. Under the bill, the Appropriations and Human Services committees must transmit these materials to DSS so they may be included in the application.

EFFECTIVE DATE: July 1, 2026

Background — Managed Care and Fee-for-Service Payment Models

Medicaid programs may deliver benefits through a managed care entity or on a fee-for-service basis. Generally, under a managed care delivery system, the Medicaid program contracts with managed care plans to cover all or most Medicaid-covered services for Medicaid

enrollees. States pay the entity administering the plan (typically, a managed care organization) a per-member, per-month amount to cover a defined set of services. Under a fee-for-service model, the state pays providers directly for each covered service delivered to a Medicaid enrollee.

§§ 18, 21 & 22 — UTILIZATION REVIEW REQUESTS AND PRIOR AUTHORIZATION

Shortens maximum response times for decisions on non-urgent prospective or concurrent review requests; establishes deadlines and related requirements for prior authorization determinations for urgent and non-urgent care requests and deems prior authorization requests approved if health carriers fail to act within set time frames; makes prior authorization approval a binding payment and coverage determination

Existing law establishes a structure and timeframe for health carriers, and any designee or utilization review company that performs utilization review on their behalf, to conduct a benefit review and notify a covered person about whether a specific medical service is reimbursable by their health insurance plan.

Non-Urgent Care Requests

The bill shortens the maximum response time allowed for decisions on non-urgent prospective or concurrent review requests, from seven calendar days to two business days. By law, unchanged by the bill, carriers may request (1) a one-time 15-day extension if the insured's provider notifies the carrier the services will not be performed for at least three months from the date the request was received and (2) a one-time five-day extension due to circumstances beyond the carrier's control and after proper notice.

The bill also requires health carriers to acknowledge receipt of a non-urgent prior authorization request within 24 hours after receiving it. At this time, under the bill, the health carrier must inform the covered person, authorized representative, or health care provider, as applicable, if any information is missing that is needed to determine the request. If the health carrier says that additional information is needed, it must approve or deny the prior authorization request within 24 hours after receiving the additional information.

Urgent Care Requests

Existing law generally requires health carriers to make a determination on an urgent care request as soon as possible and no later than 24 hours after receiving it, unless the covered person or their authorized representative failed to provide necessary information.

For urgent prior authorization requests, the bill similarly requires a health carrier to approve or deny the request, or inform the covered person, authorized representative, or the prescribing health care provider if any information is missing from the request within 24 hours after receiving the request. If additional information is needed, the health carrier must then approve or deny the request within 24 hours after receiving the necessary information.

Requests Deemed Approved

Under the bill, urgent and non-urgent prior authorization requests are deemed approved if the health carrier fails, within the above timeframes, to acknowledge receipt of a request, approve or deny a completed request, or send notice that it needs additional information.

Payment for Services Subject to Prior Authorization Requirements

Under the bill, health services that required and received prior authorization (including deemed approvals described above) must be paid following state and federal prompt payment laws. The bill makes prior authorization approval a binding determination for coverage and payment. It requires health carriers to pay claims for these services except in the following cases:

1. the covered person was ineligible for coverage when the service was rendered,
2. benefits were exhausted,
3. the prior authorization was based on materially inaccurate information from the health care provider,

4. the health carrier reasonably believes there was fraud or intentional misconduct, or
5. another health carrier is responsible.

EFFECTIVE DATE: January 1, 2027

COMMITTEE ACTION

Human Services Committee

Joint Favorable

Yea 16 Nay 7 (03/19/2026)