



Senate

General Assembly

File No. 485

February Session, 2026

Substitute Senate Bill No. 496

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 HOSPITAL UNCOMPENSATED CARE.

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

1 Section 1. (NEW) (*Effective October 1, 2026*) (a) As used in this section,
2 (1) "hospital" has the same meaning as provided in section 19a-490 of
3 the general statutes, (2) "hospital financial assistance" means any
4 program administered by a hospital or health system, including a bed
5 fund, as defined in section 19a-509b of the general statutes, that reduces,
6 in whole or in part, a patient's liability for the cost of inpatient or
7 outpatient care, and (3) "hospital financial assistance program" means a
8 program in which a participating hospital provides inpatient and
9 outpatient care:

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

12 (B) Subsidized by hospital financial assistance for an uninsured
13 patient with income exceeding two hundred per cent of the federal
14 poverty level but not exceeding three hundred per cent of the federal

15 poverty level;

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

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

29 (b) A hospital may opt in to the hospital financial assistance program
30 and be reimbursed pursuant to section 2 of this act. A participating
31 hospital shall not (1) count a patient's assets when determining
32 eligibility for hospital financial assistance, or (2) require the patient to
33 provide proof that the patient's application for benefits under the state
34 medical assistance program, Medicare, Emergency Medicaid, other
35 government-funded coverage or insurance through the Connecticut
36 Health Insurance Exchange was denied. A hospital shall use software
37 that conforms to industry standards concerning electronic income
38 verification and may accept one of the following documents to verify
39 income:

40 (A) A copy of the patient's most recent tax return;

41 (B) A copy of the patient's most recent W-2 form and 1099 forms;

42 (C) Copies of the patient's two most recent pay stubs; or

43 (D) Written income verification from an employer if the patient is
44 paid in cash.

45 (c) A participating hospital shall exempt patients who are
46 experiencing homelessness or are at imminent risk of homelessness
47 from providing documentation pursuant to subsection (b) of this section
48 but may require such patients to provide self-attested information for
49 both a hospital financial assistance screening and hospital financial
50 assistance application.

51 (d) Notwithstanding the provisions of section 19a-509b of the general
52 statutes, a participating hospital shall make information available on the
53 hospital financial assistance program in each of the top non-English
54 languages spoken by five or more per cent of the population that reside
55 in the geographic area served by the hospital. Such information shall (1)
56 be included in all discharge paperwork and on the hospital's Internet
57 web site, (2) contain contact information for the Office of the Health Care
58 Advocate, and (3) comply with requirements concerning effective
59 communications under the Americans with Disabilities Act, including,
60 but not limited to, communications delivered through relay services,
61 interpretation, large print and braille.

62 Sec. 2. (NEW) (*Effective October 1, 2026*) (a) As used in this section,
63 "disproportionate share hospital payment" means a Medicaid payment
64 to a hospital that serves a disproportionately large number of Medicaid
65 beneficiaries and uninsured individuals. The Commissioner of Social
66 Services shall amend the Medicaid state plan to use disproportionate
67 share hospital payments to compensate hospitals that participate in the
68 hospital financial assistance program established pursuant to section 1
69 of this act.

70 (b) The Commissioner of Social Services shall establish criteria for a
71 participating hospital to document hospital financial assistance and
72 receive timely payment for such assistance.

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

77 Sec. 3. Subsection (b) of section 17b-238 of the 2026 supplement to the
78 general statutes is repealed and the following is substituted in lieu
79 thereof (*Effective October 1, 2026*):

80 (b) Any institution or agency to which payments are to be made
81 under sections 17b-239 to 17b-246, inclusive, and sections 17b-340, [and]
82 17b-343 and section 2 of this act which is aggrieved by any decision of
83 said commissioner may, within ten days after written notice thereof
84 from the commissioner, obtain, by written request to the commissioner,
85 a rehearing on all items of aggrievement. On and after July 1, 1996, a
86 rehearing shall be held by the commissioner or his designee, provided a
87 detailed written description of all such items is filed within ninety days
88 of written notice of the commissioner's decision. The rehearing shall be
89 held within thirty days of the filing of the detailed written description
90 of each specific item of aggrievement. The commissioner shall issue a
91 final decision within sixty days of the close of evidence or the date on
92 which final briefs are filed, whichever occurs later. Any designee of the
93 commissioner who presides over such rehearing shall be impartial and
94 shall not be employed within the Department of Social Services office of
95 certificate of need and rate setting. Any such items not resolved at such
96 rehearing to the satisfaction of either such institution or agency or said
97 commissioner shall be submitted to binding arbitration to an arbitration
98 board consisting of one member appointed by the institution or agency,
99 one member appointed by the commissioner and one member
100 appointed by the Chief Court Administrator from among the retired
101 judges of the Superior Court, which retired judge shall be compensated
102 for his services on such board in the same manner as a state referee is
103 compensated for his services under section 52-434. The proceedings of
104 the arbitration board and any decisions rendered by such board shall be
105 conducted in accordance with the provisions of the Social Security Act,
106 49 Stat. 620 (1935), 42 USC 1396, as amended from time to time, and
107 chapter 54.

108 Sec. 4. Subsection (b) of section 17b-238 of the 2026 supplement to the
109 general statutes, as amended by section 348 of public act 25-168, is
110 repealed and the following is substituted in lieu thereof (*Effective January*

111 1, 2027):

112 (b) Any institution or agency to which payments are to be made
 113 under sections 17b-239 to 17b-246, inclusive, and sections 17b-340, [and]
 114 17b-343 and section 2 of this act which is aggrieved by any decision of
 115 said commissioner may, within ten days after written notice thereof
 116 from the commissioner, obtain, by written request to the commissioner,
 117 a rehearing on all items of aggrievement. On and after July 1, 1996, a
 118 rehearing shall be held by the commissioner or his designee, provided a
 119 detailed written description of all such items is filed within ninety days
 120 of written notice of the commissioner's decision. The rehearing shall be
 121 held within thirty days of the filing of the detailed written description
 122 of each specific item of aggrievement. The commissioner shall issue a
 123 final decision within sixty days of the close of evidence or the date on
 124 which final briefs are filed, whichever occurs later. Any designee of the
 125 commissioner who presides over such rehearing shall be impartial and
 126 shall not be employed within the Department of Social Services office of
 127 certificate of need and rate setting. Any such items not resolved at such
 128 rehearing to the satisfaction of either such institution or agency or said
 129 commissioner may be appealed in accordance with section 4-183. Such
 130 appeals shall be privileged cases to be heard by the court as soon after
 131 the return date as shall be practicable.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2026	New section
Sec. 2	October 1, 2026	New section
Sec. 3	October 1, 2026	17b-238(b)
Sec. 4	January 1, 2027	17b-238(b)

Statement of Legislative Commissioners:

Sections 1(b)(2) and (c) were redrafted for clarity; in Section 2(c), "17b-60" was changed to "17b-238" for accuracy; and Sections 3 and 4 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 \$
UConn Health Ctr.	GF - Potential Revenue Gain	See Below	See Below
Social Services, Dept.	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

Section 1 results in a potential revenue gain to the UConn Health Center (UCHC) annually beginning in FY 27. It allows any hospital, including UCHC, to participate in a financial assistance program established by the bill for patients who meet certain income and other criteria. Presumably, UCHC 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 UCHC 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.¹ On average, the uninsured patients who met the bill's

¹ 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.

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 2 results in a Medicaid cost to the Department of Social Services (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.

DSS may also incur increased administrative costs to the extent participating hospitals utilize the appeals process authorized by the bill.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the scope of allowable DSH payments.

OLR Bill Analysis**sSB 496*****AN ACT CONCERNING HOSPITAL UNCOMPENSATED CARE.*****SUMMARY**

This 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 provide free patient care.)

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

Correspondingly, the bill requires the Department of Social Services (DSS) commissioner to amend the Medicaid state plan to use DSH payments to compensate participating hospitals and set criteria for them to document the financial assistance they provide and receive timely payment for it.

Under the bill, a hospital aggrieved by the commissioner's final decision on the validity of the hospital's bills for financial assistance may request a rehearing using existing law's 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, except that the provision allowing an aggrieved hospital to request a rehearing takes effect January 1, 2027.

VOLUNTARY HOSPITAL FINANCIAL ASSISTANCE PROGRAM

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 federal poverty level (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 (a) federal Supplemental Nutrition Assistance Program (SNAP) or (b) 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 according to a payment plan that is less than 2% of their annual household income. After 36 cumulative monthly 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 their program eligibility or (2) requiring a patient to provide proof of a denial letter from a public insurance program (the Connecticut Medical Assistance Program, Emergency Medicaid, and Medicare) or insurance through the statewide health exchange (Access Health CT).

Hospitals must use software that meets 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 provide 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), the bill requires participating hospitals to make available financial assistance program information in the other languages spoken by at least 5% of the population living in the geographic area the hospital serves.

Under the bill, the information must (1) be included 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.

COMMITTEE ACTION

Human Services Committee

Joint Favorable

Yea 16 Nay 7 (03/19/2026)