General Assembly

Substitute Bill No. 5041

February Session, 2026

AN ACT CONCERNING A STUDY OF A CONNECTICUT OPTION FOR AFFORDABLE HEALTH CARE, HEALTH INSURER REQUIREMENTS FOR CERTAIN GENERIC DRUGS, TAX CREDITS FOR SMALL BUSINESS HEALTH CARE ARRANGEMENTS AND WORKER PORTABLE BENEFIT ACCOUNTS.

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

1 Section 1. (*Effective from passage*) (a) As used in this section:

2 (1) "Affordable Care Act" means the Patient Protection and
3 Affordable Care Act, P.L. 111-148, as amended by the Health Care and
4 Education Reconciliation Act, P.L. 111-152, as both may be amended
5 from time to time, and regulations adopted pursuant to said acts;

6 (2) "Connecticut Option program" means a standardized health
7 benefit plan designed by the state to reduce health care coverage costs
8 and made available through private or commercial insurance carriers to
9 individuals in the state;

10 (3) "Exchange" means the Connecticut Health Insurance Exchange
11 established under section 38a-1081 of the general statutes;

12 (4) "Health benefit plan" has the same meaning as provided in section
13 38a-1080 of the general statutes;

14 (5) "State innovation waiver" means a waiver of one or more
15 requirements of the Affordable Care Act authorized under section 1332

16 of said act; and

17 (6) "Secretary" means the Secretary of the Office of Policy and
18 Management.

19 (b) The Secretary of the Office of Policy and Management shall,
20 within available resources, study the feasibility of establishing the
21 Connecticut Option program with the goal of reducing health insurance
22 premiums. The study shall include analyses, conclusions and
23 recommendations sufficient for the secretary, in consultation with the
24 Insurance Commissioner, to evaluate and compare design models for
25 the program. The study shall include, but need not be limited to:

26 (1) A review of the efficacy, impact and reasonableness of proposed
27 program design elements, including, but not limited to: (A) Provider
28 reimbursement methodologies; (B) value-based or performance-based
29 contracting arrangements; (C) enrollee cost-sharing and premium
30 affordability targets; (D) incentives or rewards for the delivery of high-
31 quality, cost-effective health care; and (E) any state-specific premium
32 assistance programs or risk stabilization programs, including, but not
33 limited to, a state-operated reinsurance program that may maximize
34 available federal funding pursuant to a state innovation waiver;

35 (2) Identification of any necessary statutory or regulatory changes
36 required for implementation of the Connecticut Option program;

37 (3) Determination of staffing needs across state agencies to effectively
38 implement the Connecticut Option program;

39 (4) Analysis of the state insurance market and projected impacts of
40 the Connecticut Option program on persons who receive health care
41 coverage through the exchange; and

42 (5) Required state action or design elements needed to achieve
43 multiple premium savings targets.

44 (c) Not later than January 15, 2027, the secretary shall file an interim
45 report, in accordance with the provisions of section 11-4a of the general

46 statutes, on the study conducted pursuant to subsection (b) of this
47 section with the joint standing committees of the General Assembly
48 having cognizance of matters relating to appropriations and the budgets
49 of state agencies, human services and insurance and real estate. Not later
50 than January 31, 2028, the secretary shall file a final report, in accordance
51 with the provisions of section 11-4a of the general statutes, on the
52 feasibility of the Connecticut Option program and any
53 recommendations on implementing the program with the joint standing
54 committees of the General Assembly having cognizance of matters
55 relating to appropriations and the budgets of state agencies, human
56 services and insurance and real estate.

57 (d) If the secretary, in consultation with the Insurance Commissioner,
58 determines a Connecticut Option program is feasible after completion
59 of the study or related reports pursuant to subsections (b) and (c) of this
60 section, the secretary may direct the relevant state agency to develop
61 and implement a state innovation waiver or any applicable waiver from
62 federal law that may be required to maximize federal funding for the
63 program or any component part of a program design to help achieve
64 health care savings.

65 Sec. 2. (NEW) (*Effective January 1, 2027*) As used in this section and
66 section 3 of this act:

67 (1) "Biological product" has the same meaning as provided in 42 USC
68 262;

69 (2) "Biosimilar" means any biological product that is licensed under
70 42 USC 262(k);

71 (3) "Brand-name drug" means a drug that is produced or distributed
72 in accordance with an original new drug application approved under 21
73 USC 355, as amended from time to time, but does not include an
74 authorized generic drug as defined in 42 CFR 447.502, as amended from
75 time to time;

76 (4) "Formulary" means a list of prescription drugs that are covered by

77 a specific health insurance plan;

78 (5) "Generic drug" means (A) a prescription drug product that is
79 marketed or distributed in accordance with an abbreviated new drug
80 application approved under 21 USC 355, as amended from time to time,
81 (B) an authorized generic drug as defined in 42 CFR 447.502, as
82 amended from time to time, or (C) a drug that entered the market before
83 calendar year 1962 that was not originally marketed under a new
84 prescription drug product application;

85 (6) "Reference product" means (A) with respect to a generic drug, the
86 listed brand-name drug against which the generic drug is compared, in
87 accordance with 21 USC 355(j)(2)(A)(i); and (B) with respect to a
88 biosimilar, the reference biological product as defined in 42 USC 1395w-
89 3a(c)(6)(I);

90 (7) "Wholesale acquisition cost" has the same meaning as provided in
91 42 USC 1395w-3a, as amended from time to time;

92 (8) "Health benefit plan" has the same meaning as provided in section
93 38a-1080 of the general statutes; and

94 (9) "Health carrier" has the same meaning as provided in section 38a-
95 591a of the general statutes.

96 Sec. 3. (NEW) (*Effective January 1, 2027*) (a) If a generic drug (1) is
97 approved by the United States Food and Drug Administration, (2) is
98 marketed pursuant to such approval, and (3) has a wholesale acquisition
99 cost that is less than the wholesale acquisition cost of the reference
100 product on the generic drug's initial date of marketing, a health benefit
101 plan issued or renewed on or after January 1, 2027, that provides
102 coverage for a reference product at the time of the generic drug's
103 marketing date shall make the generic drug available on such health
104 benefit plan's formulary with lower cost sharing, including actual out-
105 of-pocket costs, relative to the reference product.

106 (b) If a biosimilar (1) is licensed by the United States Food and Drug

107 Administration, (2) is marketed pursuant to such licensure, and (3) has
108 a wholesale acquisition cost that is less than the wholesale acquisition
109 cost of the reference product of such biosimilar on the initial date of
110 marketing, a health benefit plan issued or renewed on or after January
111 1, 2027, that provides coverage for the biosimilar's reference product at
112 the time of the biosimilar's marketing date shall make at least one
113 biosimilar available on the formulary on a tier with lower cost sharing,
114 including actual out-of-pocket costs, relative to the reference product.

115 (c) Subsections (a) and (b) of this section shall apply as long as the
116 wholesale acquisition cost of the generic drug or biosimilar is lower than
117 the wholesale acquisition cost of the reference product.

118 (d) A health benefit plan may not restrict the pharmacies through
119 which enrollees may obtain the generic drug or biosimilar, unless the
120 same restriction applies to the reference product.

121 (e) If a generic drug or biosimilar has a lower wholesale acquisition
122 cost than its reference product, and neither the generic drug or
123 biosimilar nor the reference product is included on the health benefit
124 plan's formulary, the health benefit plan issued or renewed on or after
125 January 1, 2027, shall not impose a more restrictive formulary exception
126 process for the generic drug or biosimilar than for the reference product.

127 (f) Nothing in this section shall:

128 (1) Require a health benefit plan to provide coverage for a reference
129 product after a generic drug or biosimilar is approved or licensed, as
130 applicable, and marketed;

131 (2) Require a health benefit plan to provide coverage for a brand-
132 name drug, biological product, generic drug or biosimilar if there is a
133 determination by the pharmacy and therapeutics committee that
134 develops the plan's formulary that such drug or biological product is no
135 longer medically appropriate or cost-effective; or

136 (3) Interfere with the ability of a pharmacy or pharmacist to comply

137 with the provisions of chapter 400j of the general statutes.

138 (g) The Insurance Commissioner may adopt regulations, in
139 accordance with the provisions of chapter 54 of the general statutes, to
140 implement the provisions of this section.

141 (h) The requirements of this section:

142 (1) Apply only with respect to coverage of and cost sharing for
143 generic drugs, biosimilars and brand-name drugs when dispensed by
144 pharmacies as outpatient prescription drugs and do not apply to generic
145 drugs, biosimilars or brand-name drugs when provided by a hospital,
146 physician or other provider of health care or palliative services, other
147 than a pharmacy, incident to the services of such provider and paid for
148 by or on behalf of the relevant health benefit plan as part of the payment
149 for such services under the medical benefit of the health benefit plan;

150 (2) Do not apply to the extent that they would require coverage by a
151 health benefit plan or enrollee cost sharing for a generic drug or
152 biosimilar that is not permitted under any applicable federal law or any
153 law of this state; and

154 (3) Do not require that a health benefit plan include on its formulary
155 a generic drug or biosimilar if the health carrier has not included the
156 reference product for that generic drug or biosimilar on its formulary
157 due to a determination by the pharmacy and therapeutics committee for
158 the health benefit plan that the brand-name drug should not be covered
159 due to clinical concerns about the safety or efficacy of the brand-name
160 drug based on the strength of scientific evidence.

161 Sec. 4. (NEW) (*Effective from passage and applicable to income and taxable*
162 *years commencing on or after January 1, 2026*)(a) As used in this section:

163 (1) "Commissioner" means the Commissioner of Revenue Services;

164 (2) "Department" means the Department of Revenue Services;

165 (3) "Income year" means the income year or taxable year, as

166 determined under chapter 207, 208 or 229 of the general statutes, as the
167 case may be;

168 (4) "Qualified small business" means an employer in the state that (A)
169 is subject to tax under chapter 207, 208 or 229 of the general statutes, (B)
170 employs fewer than fifty employees in the state on the date of its
171 application under subsection (c) of this section, and (C) has adopted an
172 individual coverage health reimbursement arrangement, as described in
173 Section 9831(d) of the Internal Revenue Code, in lieu of a traditional
174 employer-provided health insurance plan;

175 (5) "Qualified contribution" means a contribution by a qualified small
176 business toward a covered employee's individual coverage health
177 reimbursement arrangement during the income year; and

178 (6) "Covered employee" means an employee for whom the qualified
179 small employer made a qualified contribution toward an individual
180 coverage health reimbursement arrangement during the income year.

181 (b) (1) There is established an individual coverage health
182 reimbursement arrangement tax credit for qualified small businesses
183 whereby a qualified small business may be allowed a tax credit against
184 the taxes imposed under chapter 207, 208 or 229 of the general statutes,
185 other than the liability imposed by section 12-707 of the general statutes.

186 (2) The amount of the credit allowed for an income year shall be equal
187 to the lesser of: (A) The sum of qualified contributions made by the
188 qualified small business during the income year, or (B) one thousand
189 dollars per covered employee. Any tax credit not used in the income
190 year during which it was earned shall expire and shall not be
191 refundable.

192 (3) A credit under this section may be allowed to a qualified small
193 business for the first income year during which the business offered an
194 individual coverage health reimbursement arrangement and the
195 immediately succeeding income year. No credit shall be allowed for any
196 other income year.

197 (c) (1) Any qualified small business planning to claim a credit under
198 the provisions of this section shall apply to the commissioner, in such
199 form and manner prescribed by the commissioner, to reserve an
200 allocation for a credit based upon the qualified contributions the
201 business intends to make. Such application shall indicate the amount of
202 qualified contributions that the business intends to make in the first
203 income year during which it offers an individual coverage health
204 reimbursement arrangement and the immediately succeeding income
205 year. The application shall contain such information as the
206 commissioner deems necessary to administer the provisions of this
207 section.

208 (2) The commissioner shall approve applications for the reservation
209 of a credit on a first-come, first-served basis and shall notify the
210 qualified small business in writing not later than thirty days after the
211 date of receipt of an application of the commissioner's approval or
212 rejection of the application. If the commissioner approves the
213 application of the qualified small business, the commissioner shall issue
214 a certification letter indicating the amount of the tax credit that has been
215 reserved for such business during each of the two income years for
216 which it is eligible to claim the credit. A qualified small business may
217 not claim a credit under this section in excess of the amount reserved by
218 the commissioner.

219 (3) The total amount of tax credits reserved under this section shall
220 not exceed five million dollars for any income year.

221 (d) If the qualified small business is an S corporation or an entity
222 treated as a partnership for federal income tax purposes, the tax credit
223 may be claimed by the shareholders or partners of the qualified small
224 business. If the qualified small business is a single member limited
225 liability company that is disregarded as an entity separate from its
226 owner, the tax credit may be claimed by the limited liability company's
227 owner.

228 Sec. 5. (NEW) (*Effective October 1, 2026*) (a) As used in this section:

229 (1) "Hiring party" means an entity who hires or enters into a contract
230 with an eligible worker;

231 (2) "Eligible worker" means an individual whose compensation is
232 reported or required to be reported on an Internal Revenue Service Form
233 1099 by a hiring party;

234 (3) "Portable benefit account" means an account owned by a person
235 that is administered by a portable benefit account provider for the
236 purposes of purchasing health insurance and health-related expenses by
237 an eligible worker; and

238 (4) "Portable benefit account provider" means (A) a bank, (B) an
239 investment management firm, or (C) a technology provider or program
240 manager that offers services through a bank or investment management
241 firm.

242 (b) Any hiring party may contribute to one or more portable benefit
243 accounts as a form of compensation to an eligible worker.

244 (c) Making or receiving contributions to a portable benefit account
245 shall not be used as a criterion for determining a worker's employment
246 classification pursuant to any provision of the general statutes.

247 (d) Hiring parties may withhold a percentage of funds owed in
248 compensation to an eligible worker for deposit into a portable benefit
249 account if (1) withholding such compensation is agreed to in writing
250 between the hiring party and the eligible worker; (2) the eligible worker
251 voluntarily enters into such an arrangement; and (3) the written
252 agreement clearly outlines the process to end the arrangement to
253 withhold owed compensation to the eligible worker.

254 (e) At any time, an eligible worker may opt out of a compensation
255 withholding arrangement by notifying the hiring party in writing.
256 Hiring parties shall return all withheld compensation owed to any
257 eligible worker not later than fifteen days after the hiring party is
258 notified in writing of the eligible worker's decision to terminate the

259 withholding arrangement.

260 Sec. 6. Section 19a-754c of the general statutes is repealed and the
261 following is substituted in lieu thereof (*Effective from passage*):

262 (a) For the purposes of this section:

263 (1) "Affordable Care Act" has the same meaning as provided in
264 section 38a-1080;

265 (2) "Covered Connecticut program" means the program established
266 under subsection (b) of this section;

267 (3) "Exchange" has the same meaning as provided in section 38a-1080;

268 (4) "Health carrier" has the same meaning as provided in section 38a-
269 1080;

270 (5) "Individual market" has the same meaning as provided in 42 USC
271 18024(a), as amended from time to time; <u>and</u>

272 **[**(6) "Office of Health Strategy" means the Office of Health Strategy
273 established under section 19a-754a; and**]**

274 **[**(7)**]** <u>(6)</u> "Silver level" has the same meaning as provided in 42 USC
275 18022(d), as amended from time to time.

276 (b) There is established within the Department of Social Services the
277 Covered Connecticut program for the purpose of reducing the state's
278 uninsured rate. The Commissioner of Social Services shall administer
279 said program in consultation with the **[**Office of Health Strategy,**]**
280 Insurance Commissioner and exchange, and, as part of said program,
281 the Department of Social Services shall:

282 (1) Provide premium and cost-sharing subsidies that are sufficient to
283 ensure fully subsidized <u>premium</u> coverage:

284 (A) On and after July 1, 2021, for parents and needy caretaker
285 relatives, and their tax dependents not older than twenty-six years of

286 age, who (i) are eligible for premium and cost-sharing subsidies for a
287 qualified health plan, (ii) are ineligible for Medicaid because their
288 income exceeds the Medicaid income limits under chapter 319v, (iii)
289 have household income up to one hundred seventy-five per cent of the
290 federal poverty level, (iv) are receiving coverage under a qualified
291 health plan offered through the exchange in the individual market at a
292 silver level of coverage, and (v) are utilizing the full amount of
293 applicable premium subsidies for such plan;

294 (B) On and after July 1, 2021, for the following additional family
295 members of parents and caretaker relatives receiving coverage under
296 such qualified health plan, provided the requirements of subparagraph
297 (A) of subdivision (1) of this subsection are met: (i) A child over twenty-
298 six years of age who is permanently and totally disabled, as defined by
299 the Internal Revenue Service pursuant to 26 USC 152, or (ii) a child who
300 is over the age of twenty-six and is incapable of self-sustaining
301 employment by reason of mental or physical handicap and is chiefly
302 dependent upon the parent or caretaker relative for support and
303 maintenance, as described in sections 38a-489 and 38a-512a, or (iii) a
304 child or stepchild receiving coverage under such qualified health plan
305 as described in sections 38a-497 and 38a-512b;

306 (C) On and after July 1, 2022, for all parents, needy caretaker relatives
307 and low-income adults who (i) are at least nineteen but not more than
308 sixty-four years of age, (ii) are eligible for premium and cost-sharing
309 subsidies for a qualified health plan, (iii) are ineligible for Medicaid
310 because their income exceeds the Medicaid income limits under chapter
311 319v, (iv) have household income up to one hundred seventy-five per
312 cent of the federal poverty level, (v) are receiving coverage under a
313 qualified health plan offered through the exchange in the individual
314 market at a silver level of coverage, and (vi) are utilizing the full amount
315 of applicable premium subsidies for such plan; and

316 (D) On and after July 1, 2022, for the following additional family
317 members of parents, caretaker relatives, and adults receiving coverage
318 under such qualified health plan, provided the requirements of

319 subparagraph (C) of subdivision (1) of this subsection are met: (i) A
320 child over twenty-six years of age who is permanently and totally
321 disabled, as defined by the Internal Revenue Service pursuant to 26 USC
322 152, or (ii) a child who is over the age of twenty-six and is incapable of
323 self-sustaining employment by reason of mental or physical handicap
324 and is chiefly dependent upon the parent or caretaker relative for
325 support and maintenance, as described in sections 38a-489 and 38a-512a,
326 or (iii) a child or stepchild, as described in sections 38a-497 and 38a-512b.

327 **[**(2) Not earlier than July 1, 2022, provide dental and nonemergency
328 medical transportation services, as provided under chapter 319v, to all
329 eligible individuals described in subdivision (1) of this subsection;**]**

330 **[**(3)**]** <u>(2)</u> Establish procedures to, on a quarterly basis, pay in
331 reimbursement to each health carrier offering the qualified health plan
332 described in subparagraph (A) or (B) of subdivision (1) of this
333 subsection, as applicable, the premium and cost-sharing subsidies
334 required under subdivision (1) of this subsection to ensure fully
335 subsidized coverage; and

336 **[**(4)**]** <u>(3)</u> Consult with the **[**Office of Health Strategy and**]** Insurance
337 Commissioner for the purposes set forth in section 17b-312.

338 <u>(c) On or after January 1, 2027, the Department of Social Services may,</u>
339 <u>as part of the Covered Connecticut program, provide dental and</u>
340 <u>nonemergency medical transportation services, as provided under</u>
341 <u>chapter 319v, to all eligible individuals described in subsection (b) of</u>
342 <u>this section.</u>

343 **[**(c)**]** <u>(d)</u> (1) The **[**Office of Health Strategy**]** <u>Department of Social</u>
344 <u>Services</u> may, subject to the approval required under subdivision (3) of
345 this subsection, seek a waiver pursuant to Section 1332 of the Affordable
346 Care Act, as amended from time to time, to advance the purpose of the
347 Covered Connecticut program. The **[**Office of Health Strategy**]**
348 <u>department</u> shall implement such waiver if the federal government
349 issues such waiver.

350 (2) The [Office of Health Strategy] Department of Social Services shall
351 submit a report, in accordance with section 11-4a, to the joint standing
352 committees of the General Assembly having cognizance of matters
353 relating to appropriations, human services and insurance containing
354 any proposed waiver described in subdivision (1) of this subsection
355 before seeking such waiver from the federal government.

356 (3) Not later than thirty days after the [Office of Health Strategy]
357 Department of Social Services submits a report under subdivision (2) of
358 this subsection, the joint standing committees of the General Assembly
359 having cognizance of matters relating to appropriations, human
360 services and insurance shall convene a joint public hearing on the
361 proposed waiver contained in the report, [submitted pursuant to
362 subdivision (2) of this subsection,] separately vote to approve or reject
363 such proposed waiver and advise the [Office of Health Strategy]
364 department of their approval or rejection of such proposed waiver. If
365 any committee takes no action on such proposed waiver within the
366 thirty-day period, the proposed waiver shall be deemed rejected.

367 [(d)] (e) The benefits and subsidies provided for individuals as part
368 of the Covered Connecticut program shall not be considered income for
369 such individuals for the purposes of chapter 229.

370 [(e) Not later than January 1, 2022, every six months thereafter
371 through January 1, 2024, and annually after January 1, 2024, the] (f) The
372 Commissioner of Social Services shall annually submit a report, in
373 accordance with section 11-4a, to the joint standing committees of the
374 General Assembly having cognizance of matters relating to
375 appropriations, human services and insurance. Such report shall contain
376 a description of the operations and finances of, and progress made by,
377 the Covered Connecticut program for the immediately preceding
378 reporting period.

379 [(f) Notwithstanding any provision of this section] (g) On or before
380 January 1, 2028, subject to federal approval, the Covered Connecticut
381 program shall only include in-network health care providers and in-

382 network services, unless the health carrier's network is deemed by the
383 Insurance Commissioner to be inadequate. Benefits described in
384 subsection (b) of this section and cost-sharing available to all eligible
385 individuals pursuant to subdivision (1) of subsection (b) of this section
386 shall only apply if such eligible individuals use in-network health care
387 providers or in-network facilities.

388 (h) (1) Notwithstanding any provision of this section, the
389 Commissioner of Social Services may make program design changes as
390 necessary to meet requirements for approval, renewal or continuation
391 of the federal waiver approved under Section 1115 of the Social Security
392 Act pursuant to which the Covered Connecticut program is
393 administered.

394 (2) The Commissioner of Social Services may, in consultation with the
395 Office of Policy and Management, prior to the expiration of such federal
396 waiver, explore, develop or pursue approval of alternative program
397 designs, including, but not limited to, a basic health plan that enables
398 coverage for applicants with household incomes of up to two hundred
399 per cent of the federal poverty level pursuant to Section 1331 of the
400 Affordable Care Act, as amended from time to time.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*January 1, 2027*	New section
Sec. 3	*January 1, 2027*	New section
Sec. 4	*from passage and applicable to income and taxable years commencing on or after January 1, 2026*	New section
Sec. 5	*October 1, 2026*	New section
Sec. 6	*from passage*	19a-754c

HS *Joint Favorable Subst. -LCO*

FIN *Joint Favorable*