



General Assembly

February Session, 2026

Substitute Bill No. 3



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*