General Assembly **Substitute Bill No. 3**

February Session, 2026

SB00003APP 042026

AN ACT CONCERNING HEALTH CARE AFFORDABILITY.

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

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

(b) The amounts on deposit in said fund shall not constitute property of the state and said fund shall not be construed to be a department, institution or agency of the state. Amounts on deposit in said fund shall not be commingled with state funds and the state shall have no claim to or against, or any interest in, such deposits. Any contract entered into by or any obligation of said fund shall not constitute a debt or obligation of the state and the state shall have no obligation to any person on account of said fund and all amounts obligated to be paid from said fund shall be limited to amounts available for such obligation on deposit in said fund. Said fund shall continue in existence as long as it holds any deposits or has any obligations and until its existence is terminated by law.

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

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

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

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

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

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

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

(6) Sue and be sued;

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

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

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

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

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

As used in sections 3-13 to 3-13e, inclusive, and 3-31b, "trust funds" includes the Connecticut Municipal Employees' Retirement Fund A, the Connecticut Municipal Employees' Retirement Fund B, the Soldiers, Sailors and Marines Fund, the Family and Medical Leave Insurance Trust Fund, the State's Attorneys' Retirement Fund, the Teachers' Annuity Fund, the Teachers' Pension Fund, the Teachers' Survivorship and Dependency Fund, the School Fund, the State Employees Retirement Fund, the Hospital Insurance Fund, the Policemen and Firemen Survivor's Benefit Fund, any trust fund described in subdivision (1) of subsection (b) of section 7-450 that is administered, held or invested by the State Treasurer, the Connecticut Baby Bond Trust, any Climate Change and Coastal Resiliency Reserve Fund created pursuant to section 7-159d, the Early Childhood Education Endowment, the Connecticut Affordable Health Care Trust Fund established pursuant to section 1 of this act and all other trust funds administered, held or invested by the State Treasurer.

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

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

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

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

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

(4) "Eligible enrollee" means a resident of the state who is eligible to enroll in a qualified health plan on Access Health Connecticut and (A) has household income not exceeding two hundred per cent of the federal poverty level and is ineligible for the Covered Connecticut program established pursuant to section 19a-754c of the general statutes, or (B) has household income exceeding four hundred per cent of the federal poverty level but not exceeding six hundred per cent of the federal poverty level and is ineligible for federal premium subsidies under the Affordable Care Act.

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

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

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

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

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

(d) In designing and implementing the Connecticut Option program, the Secretary of the Office of Policy and Management shall adopt the Connecticut Option program recommended by the working group established pursuant to section 7 of this act based on (1) analyses of affordability, (2) projected impact on rates of uninsured persons, (3) protection against adverse selection, (4) comprehensiveness of benefits, and (5) impact on equitable access to health care and sustainability. The secretary may:

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

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

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

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

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

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

(2) "Eligible individual" means a state resident who (A) is under sixty-five years of age, (B) has household income exceeding one hundred thirty-three per cent of the federal poverty level but not exceeding two hundred per cent of the federal poverty level, (C) is otherwise ineligible

for medical assistance programs established pursuant to chapter 319v of the general statutes, and (D) is otherwise eligible to enroll in a qualified health plan, as defined in section 38a-1080 of the general statutes, on Access Health Connecticut, as defined in section 4 of this act; and

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

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

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

(d) If the commissioner determines that the cost of medical assistance provided to eligible individuals in the basic health program will exceed federal subsidies, or if changes in federal law, regulations or the administration of federal law or regulations affects funding, eligibility for or administration of the program, the commissioner, in consultation with the Office of Policy and Management, may develop a plan to respond to such changes. To the extent that federal funds received under the Affordable Care Act for the basic health program exceed the cost of medical assistance that would otherwise be provided to eligible

individuals, the commissioner shall use such funds to reduce the premiums and cost-sharing of, or provide additional benefits for, eligible individuals in accordance with 42 USC 18051, as amended from time to time.

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

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

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

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

(b) The working group shall consist of:

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

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

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

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

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

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

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

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

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

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

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

(12) Any other members the chairpersons deem necessary.

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

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

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

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

(g) The members of the working group shall serve without compensation, but shall, within the limits of available funds and subject to the approval of the working group's chairpersons, be reimbursed for expenses necessarily incurred in the performance of their duties.

(h) Not later than December 1, 2026, the working group shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets

of state agencies, human services and insurance and real estate concerning the group's recommendations for the design and implementation of the Connecticut Option program and the basic health program. Such report shall contain a description of the programs, including, but not limited to, operations and funding for the programs.

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

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

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

(b) Notwithstanding the provisions of subsection (a) of this section, it shall be the joint duty of each spouse to support his or her family, and both, except as provided in subsection (d) of this section, shall be liable for: (1) The reasonable and necessary services of a physician or dentist; (2) hospital expenses rendered the husband or wife or minor child while residing in the family of his or her parents; (3) the rental of any dwelling unit actually occupied by the husband and wife as a residence and reasonably necessary to them for that purpose; and (4) any article purchased by either which has in fact gone to the support of the family,

or for the joint benefit of both.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A hospital aggrieved by a final decision of the commissioner on the validity of such hospital's bills for hospital financial assistance may

file an appeal in accordance with the provisions of section 17b-238 of the general statutes, as amended by this act.

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

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

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

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

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

(4) One person with expertise in health and human services policy administration, one person with expertise in data science, analytics or interagency data integration and one person with expertise in user experience or person-centered design of such programs, all appointed jointly by and serving at the pleasure of the chairpersons of the working group;

(5) The chief executive officer of Access Health Connecticut, as

defined in section 4 of this act;

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

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

(c) The working group shall:

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

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

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

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

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

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

(1) An estimate of the number and percentage of Medicaid and supplemental nutrition assistance program beneficiaries in the state

who may qualify for exemptions from work or community engagement requirements imposed by the federal Fiscal Responsibility Act of 2023, P.L. 118-5 and Section 71119 of P.L. 119-21;

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

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

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

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

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

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

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

(2) The number of beneficiaries who have lost and are expected to

lose eligibility for the supplemental nutrition assistance and Medicaid programs since implementation of such requirements under P.L. 119-21;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Determining whether an individual qualifies for an exemption

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The categories of data to be shared;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) With respect to a nonurgent care request:

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

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

(C) If a health carrier notifies a covered person, authorized

representative or health care provider pursuant to subparagraph (B) of this subdivision that additional information is necessary, the health carrier shall approve or deny the prior authorization request not later than twenty-four hours after receipt of such information.

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

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

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

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

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

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

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

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

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

(c) With respect to an urgent care request:

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

(B) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, for an urgent care request specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, the health carrier shall make a determination as soon as possible, taking

into account the covered person's medical condition, but not later than twenty-four hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made not less than twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

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

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

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

(d) (1) If a health carrier fails, within the time periods specified in

subsections (b) and (c) of this section, to approve or deny a completed prior authorization request, acknowledge receipt of the request or notify the covered person, authorized representative or health care provider that additional information is required, the prior authorization request shall be deemed approved. Whenever a health carrier receives a review request from a covered person or a covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of such failure not later than five calendar days after the health carrier receives such request, except that for an urgent care request, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of such failure not later than twenty-four hours after the health carrier receives such request. For a nonurgent prospective or concurrent review request, each health carrier shall acknowledge receipt of each such request as soon as practicable, but not later than twenty-four hours after the health carrier receives such request, except that such health carrier shall respond in less time if such a response is required by applicable federal law.

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

(e) (1) Any service for which prior authorization was required and received, including deemed approvals, shall be paid in accordance with state and federal prompt payment laws. A health carrier shall pay claims for health care services for which prior authorization was required by and received from the health carrier, including any prior authorization deemed approved pursuant to subsection (d) of this section, except

where: (A) The covered person was not eligible for coverage at the time services were rendered; (B) benefits were exhausted; (C) the prior authorization was based on materially inaccurate information provided by the health care provider; (D) the health carrier has a reasonable belief that fraud or intentional misconduct occurred; or (E) another health carrier is responsible pursuant to coordination of benefits. Prior authorization approval, whether express or deemed approved, shall constitute a binding determination with respect to coverage and payment. Each health carrier shall provide promptly to a covered person and, if applicable, the covered person's authorized representative a notice of an adverse determination.

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

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

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

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

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

(E) A description of the health carrier's internal grievance process that includes (i) the health carrier's expedited review procedures, (ii) any time limits applicable to such process or procedures, (iii) the contact

information for the organizational unit designated to coordinate the review on behalf of the health carrier, and (iv) a statement that the covered person or, if applicable, the covered person's authorized representative is entitled, pursuant to the requirements of the health carrier's internal grievance process, to receive from the health carrier, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the covered person's benefit request;

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

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

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

(I) A statement, expressed in language approved by the Healthcare Advocate and prominently displayed on the first page or cover sheet of the notice using a call-out box and large or bold text, that if the covered person or the covered person's authorized representative chooses to file a grievance of an adverse determination, (i) such appeals are sometimes successful, (ii) such covered person or covered person's authorized representative may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person or covered person's authorized representative with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time, (iii) such covered person or covered person's authorized representative is entitled and encouraged to submit supporting documentation for the health carrier's consideration during the review of an adverse determination, including narratives from such covered person or covered person's authorized representative and letters and treatment notes from such covered person's health care professional, and (iv) such covered person or covered person's authorized representative has the right to ask such covered person's health care professional for such letters or treatment notes.

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

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

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

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

(3) A disclosure that the covered person or the covered person's

authorized representative may file immediately, without waiting for the date such advance notice of the proposed rescission ends, a grievance with the health carrier to request a review of the adverse determination to rescind coverage, pursuant to sections 38a-591e and 38a-591f;

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

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

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

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

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

(b) Any institution or agency to which payments are to be made under sections 17b-239 to 17b-246, inclusive, and sections 17b-340, **[**and**]** 17b-343 and section 11 of this act which is aggrieved by any decision of said commissioner may, within ten days after written notice thereof

from the commissioner, obtain, by written request to the commissioner, a rehearing on all items of aggrievement. On and after July 1, 1996, a rehearing shall be held by the commissioner or his designee, provided a detailed written description of all such items is filed within ninety days of written notice of the commissioner's decision. The rehearing shall be held within thirty days of the filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision within sixty days of the close of evidence or the date on which final briefs are filed, whichever occurs later. Any designee of the commissioner who presides over such rehearing shall be impartial and shall not be employed within the Department of Social Services office of certificate of need and rate setting. Any such items not resolved at such rehearing to the satisfaction of either such institution or agency or said commissioner shall be submitted to binding arbitration to an arbitration board consisting of one member appointed by the institution or agency, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434. The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396, as amended from time to time, and chapter 54.

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

(b) Any institution or agency to which payments are to be made under sections 17b-239 to 17b-246, inclusive, and sections 17b-340, **[**and**]** 17b-343 and section 11 of this act which is aggrieved by any decision of said commissioner may, within ten days after written notice thereof from the commissioner, obtain, by written request to the commissioner, a rehearing on all items of aggrievement. On and after July 1, 1996, a

rehearing shall be held by the commissioner or his designee, provided a detailed written description of all such items is filed within ninety days of written notice of the commissioner's decision. The rehearing shall be held within thirty days of the filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision within sixty days of the close of evidence or the date on which final briefs are filed, whichever occurs later. Any designee of the commissioner who presides over such rehearing shall be impartial and shall not be employed within the Department of Social Services office of certificate of need and rate setting. Any such items not resolved at such rehearing to the satisfaction of either such institution or agency or said commissioner may be appealed in accordance with section 4-183. Such appeals shall be privileged cases to be heard by the court as soon after the return date as shall be practicable.

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

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

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

(a) (1) Upon request pursuant to subparagraph (E) of subdivision **[**(1)**]** (2) of subsection (e) of section 38a-591d, as amended by this act, the health carrier shall provide free of charge to a covered person or a covered person's authorized representative, as applicable, copies of all documents, communications, information and evidence, including

citations to any medical journals, regarding the covered person's benefit request that is the subject of the adverse determination that were not submitted by the covered person or the covered person's authorized representative and were available to the health carrier or the utilization review entity that made the adverse determination at the time such adverse determination was made.

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

HS *Joint Favorable Subst. -LCO*

APP *Joint Favorable*