
OLR Bill Analysis

sSB 3

AN ACT CONCERNING HEALTH CARE AFFORDABILITY.

TABLE OF CONTENTS:

SUMMARY

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

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

§ 4 — CONNECTICUT OPTION AFFORDABLE HEALTH CARE PROGRAM

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

§§ 5 & 6 — BASIC HEALTH PROGRAM

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

§ 7 — CONNECTICUT OPTION AND BHP WORKING GROUP

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

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

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

§ 9 — SPOUSAL MEDICAL DEBT

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

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

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

§ 12 — SAFETY NET MITIGATION WORKING GROUP

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

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

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

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

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

§ 15 — DSS DATA ACCESS AND EMPLOYMENT VERIFICATION

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

§ 16 — “MEDICAL FRAILTY” DEFINITION

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

§ 17 — LEGISLATIVE REVIEW OF MEDICAID PAYMENT MODEL CHANGES

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

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

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

SUMMARY

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

EFFECTIVE DATE: Various, see below.

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

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

The bill establishes the Connecticut Affordable Health Care Trust

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

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

Funds in the trust are not state property; they cannot be combined with state funds and the state has no claim on them. Similarly, contracts and obligations associated with the trust are not state debts or obligations. Under the bill, the state has no obligation to any person on account of the trust. Also, amounts obligated to be paid from the trust are limited to what is deposited in it.

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

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

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

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

1. receive and invest money in the fund in any instruments, obligations, securities, or property;
2. enter into contracts for services for the fund (such as legal, actuarial, accounting, advisory, and management) and pay for services from the fund's assets;
3. obtain insurance in connection with the fund's property, assets, activities, or deposits;
4. apply for and accept gifts, grants, or donations;
5. adopt regulations;
6. sue and be sued;
7. establish accounts within the fund; and
8. take any other action needed to carry out the bill's purposes and related to the bill's duties for the treasurer.

EFFECTIVE DATE: July 1, 2026

§ 4 — CONNECTICUT OPTION AFFORDABLE HEALTH CARE PROGRAM

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

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

EFFECTIVE DATE: Upon passage

Program Benefits and Eligibility

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

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

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

Program Design and Implementation

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

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

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

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

The bill authorizes the OPM secretary to:

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

Reporting Requirement

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

Background — Related Bills

sHB 5041, favorably reported by the Human Services Committee, and

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

§§ 5 & 6 — BASIC HEALTH PROGRAM

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

Starting October 1, 2026, the bill requires DSS, in consultation with OPM and based on recommendations from a working group the bill establishes (see § 7), to seek any necessary approvals from the federal government to establish a basic health program (BHP, see *Background – BHP*) and take all necessary actions to maximize federal funding. (The working group’s report is not due until December 1, 2026.)

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

Program Administration and Benefits

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

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

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

Under the bill, if the federal subsidies the state receives to pay for the BHP exceed the cost of care that would otherwise be provided to eligible individuals, the commissioner must use them to reduce these

individuals' premiums and cost sharing or provide additional benefits.

Eligibility Requirements

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

BHP Account

The bill establishes a separate, nonlapsing BHP account, which contains any moneys required by law to be deposited into it (for example, federal subsidies) and DSS must use the funds solely to operate the program.

Federal Applications and Reporting Requirement

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

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

Background — BHP

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

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

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

The law requires states to establish funds into which the federal subsidies are deposited and can be used only to reduce BHP enrollees’ premiums and cost sharing or to give them additional benefits (42 U.S.C. § 18051).

Background — Related Bill

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

§ 7 — CONNECTICUT OPTION AND BHP WORKING GROUP

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

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

EFFECTIVE DATE: Upon passage

Connecticut Option and BHP Recommendations

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

Working Group Members and Structure

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

1. Connecticut healthcare advocate;
2. CID and DSS commissioners and the OPM Secretary;
3. Commission on Racial Equity and Public Health executive director;
4. state comptroller;
5. the six legislative leaders;
6. chairpersons of the Insurance and Real Estate Committee; and
7. Access Health CT chief executive officer.

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

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

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

Under the bill, a majority of working group members is a quorum to transact business and the working group makes decisions by majority

vote of members present at a meeting, except that the co-chairpersons can establish committees, sub-committees, or other entities as they deem necessary to further the working group's purposes. The bill allows the working group to adopt rules of procedure.

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

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

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

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

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

EFFECTIVE DATE: July 1, 2026

§ 9 — SPOUSAL MEDICAL DEBT

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

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

covered by the deceased spouse's estate and (2) related to hospital expenses or reasonable and necessary physician or dentist services.

EFFECTIVE DATE: July 1, 2026

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

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

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

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

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

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

EFFECTIVE DATE: October 1, 2026

Care Requirements

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

1. for free to uninsured patients with income up to 200% of the FPL;
2. subsidized care to uninsured patients with income between 201% and 300% FPL; and
3. subsidized care for patients with income up to 400% FPL who are enrolled in the federal Supplemental Nutrition Assistance Program (SNAP) or Special Supplemental Food Program for Women, Infants, and Children (WIC).

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

Eligibility Requirements

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

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

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

cash.

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

Program Information in Other Languages

Regardless of the state’s law on hospital bed funds (see *Background – Hospital Bed Fund Patient Summaries*), the bill requires participating hospitals to make available financial assistance program information in the languages spoken by 5% or more of the population living in the geographic area the hospital serves.

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

Background — Hospital Bed Fund Patient Summaries

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

Background — Related Bill

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

§ 12 — SAFETY NET MITIGATION WORKING GROUP

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

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

Working Group Membership

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

1. OPM secretary;
2. DSS, Department of Revenue Services, Department of Mental Health and Addiction Services, Department of Developmental Services, Department of Public Health (DPH), Insurance Department, and Department of Labor (DOL) commissioners; and
3. chairpersons of the Appropriations, Housing, Human Services, and Insurance and Real Estate committees, who must jointly choose the working group's chairpersons.

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

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

Working Group Duties

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

1. review any significant changes in federal law or policy impacting public health, social services, or other safety net programs;
2. evaluate the current or projected operational and fiscal impacts of these changes on agency procurement and service delivery;
3. recommend budgetary, regulatory, administrative, or legislative

measures to mitigate adverse procurement or service outcomes to OPM and the Appropriations, Housing, Human Services, and Insurance and Real Estate committees; and

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

Annual Report

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

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

EFFECTIVE DATE: Upon passage

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

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

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

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

1. implementation of federal law on work and community engagement requirements for Medicaid and SNAP under P.L 119-21;
2. the number of beneficiaries who lost or are expected to lose eligibility for SNAP and Medicaid since implementing requirements;
3. copies of any documentation or reporting given to the federal government related to these requirements;
4. a list of changes to contracts with existing vendors and requests for proposals for new vendors related to these requirements;
5. a list of data sources being used for automatic verification of work or income status or qualifications for exemptions from the requirements;
6. records related to how (a) DSS will define “medical frailty” for potential exemptions (see § 16) and (b) compliance verification will be streamlined for SNAP and Medicaid recipients;
7. a summary of how SNAP and Medicaid recipients will be engaged in the decision-making process;
8. a long-term plan for ongoing information sharing and support for Medicaid and SNAP recipients and providers to minimize

disenrollment of eligible individuals; and

9. statistics on DSS's customer service telephone call center, including average response time to calls, call abandonment rate, level of staff attrition, and details on new staff hired in the past fiscal year.

EFFECTIVE DATE: Upon passage

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

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

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

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

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

EFFECTIVE DATE: Upon passage

§ 15 — DSS DATA ACCESS AND EMPLOYMENT VERIFICATION

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

The bill requires DSS to receive or have access to data kept by other

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

EFFECTIVE DATE: Upon passage

Data Uses

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

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

Types of Data

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

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

needed to verify federal exemption eligibility criteria.

Limits on Data Use

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

1. identifying and verifying if someone qualifies for an exemption from SNAP work requirements or Medicaid community engagement requirements and
2. determining if someone has met work or community engagement requirements to facilitate enrollment and automatic eligibility renewal.

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

Employment Verification Systems and Programs

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

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

Interagency Data-Sharing Agreements

The bill requires DSS to enter into interagency data-sharing agreements with each agency from which it accesses or receives data for

these purposes. The agreements must specify data categories to be shared, the data's purpose and ways it will be used, procedures to ensure data security and compliance with applicable privacy laws, and limits on further data use or disclosure.

Data Disclosure Notice

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

Confidentiality, Privacy, and Security Laws

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

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

§ 16 — “MEDICAL FRAILTY” DEFINITION

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

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

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

1. existing definitions in state statutes and regulations for similar

- physical conditions;
2. medical frailty definitions in other states;
 3. related medical codes for diagnosing a medical frailty classification; and
 4. ways to streamline the classification across DSS-administered programs that **enroll** medically frail people (presumably, after the definition of this term is developed).

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

EFFECTIVE DATE: Upon passage

§ 17 — LEGISLATIVE REVIEW OF MEDICAID PAYMENT MODEL CHANGES

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

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

Comment Period and Hearing

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

1. hold a public hearing within 30 days after they receive the proposal;
2. notify the DSS commissioner about the hearing's date and time at least 15 days before it; and

3. invite her to testify, including about any costs or benefits to the state and expected impacts on care provided to Medicaid recipients and Medicaid provider payments.

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

Conference Committee

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

Proposals Deemed Denied

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

Implementation Application

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

EFFECTIVE DATE: July 1, 2026

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

Medicaid programs may deliver benefits through a managed care entity or on a fee-for-service basis. Generally, under a managed care delivery system, the Medicaid program contracts with managed care plans to cover all or most Medicaid-covered services for Medicaid enrollees. States pay the entity administering the plan (typically, a managed care organization) a per-member, per-month amount to cover a defined set of services. Under a fee-for-service model, the state pays providers directly for each covered service delivered to a Medicaid enrollee.

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

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

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

Non-Urgent Care Requests

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

The bill also requires health carriers to acknowledge receipt of a non-urgent prior authorization request within 24 hours after receiving it. At this time, under the bill, the health carrier must inform the covered

person, authorized representative, or health care provider, as applicable, if any information is missing that is needed to determine the request. If the health carrier says that additional information is needed, it must approve or deny the prior authorization request within 24 hours after receiving the additional information.

Urgent Care Requests

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

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

Requests Deemed Approved

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

Payment for Services Subject to Prior Authorization Requirements

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

1. the covered person was ineligible for coverage when the service was rendered,

2. benefits were exhausted,
3. the prior authorization was based on materially inaccurate information from the health care provider,
4. the health carrier reasonably believes there was fraud or intentional misconduct, or
5. another health carrier is responsible.

EFFECTIVE DATE: January 1, 2027

COMMITTEE ACTION

Human Services Committee

Joint Favorable

Yea 16 Nay 7 (03/19/2026)