



House of Representatives

File No. 903

General Assembly

January Session, 2025

(Reprint of File No. 107)

Substitute House Bill No. 6771
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 12, 2025

AN ACT ESTABLISHING AN ALZHEIMER'S DISEASE AND DEMENTIA TASK FORCE, REQUIRING HEALTH INSURANCE COVERAGE FOR BIOMARKER TESTING AND CONCERNING TRANSFERS AND DISCHARGES IN RESIDENTIAL CARE HOMES, TUITION WAIVERS FOR NURSING HOME RESIDENTS WHO TAKE COURSES AT REGIONAL COMMUNITY-TECHNICAL COLLEGES AND CLOSURES AND EVACUATIONS OF RESIDENTIAL CARE HOMES AND NURSING HOMES.

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

1 Section 1. Subsections (a) to (c), inclusive, of section 19a-491c of the
2 general statutes are repealed and the following is substituted in lieu
3 thereof (*Effective October 1, 2025*):

4 (a) As used in this section:

5 (1) "Criminal history and patient abuse background search" or
6 "background search" means (A) a review of the registry of nurse's aides
7 maintained by the Department of Public Health pursuant to section 20-
8 102bb, (B) checks of state and national criminal history records

9 conducted in accordance with section 29-17a, and (C) a review of any
10 other registry specified by the Department of Public Health which the
11 department deems necessary for the administration of a background
12 search program.

13 (2) "Direct access" means physical access to a patient or resident of a
14 long-term care facility that affords an individual with the opportunity
15 to commit abuse or neglect against or misappropriate the property of a
16 patient or resident.

17 (3) "Disqualifying offense" means a conviction of (A) any crime
18 described in 42 USC 1320a-7(a)(1), (2), (3) or (4), (B) a substantiated
19 finding of neglect, abuse or misappropriation of property by a state or
20 federal agency pursuant to an investigation conducted in accordance
21 with 42 USC 1395i-3(g)(1)(C) or 42 USC 1396r(g)(1)(C), or (C) a
22 conviction of any crime described in section 53a-59a, 53a-60b, 53a-60c,
23 53a-61a, 53a-321, 53a-322 or 53a-323.

24 (4) "Long-term care facility" means any facility, agency or provider
25 that is a nursing home, as defined in section 19a-521, a residential care
26 home, as defined in section 19a-521, a home health care agency, hospice
27 agency or home health aide agency, as defined in section 19a-490, an
28 assisted living services agency, as defined in section 19a-490, an
29 intermediate care facility for individuals with intellectual disabilities, as
30 defined in 42 USC 1396d(d), except any such facility operated by a
31 Department of Developmental Services' program subject to background
32 checks pursuant to section 17a-227a, a chronic disease hospital, as
33 defined in section 19a-490, or an agency providing hospice care which
34 is licensed to provide such care by the Department of Public Health or
35 certified to provide such care pursuant to 42 USC 1395x.

36 (b) The Department of Public Health shall create and implement a
37 criminal history and patient abuse background search program, within
38 available appropriations, in order to facilitate the performance,
39 processing and analysis of the criminal history and patient abuse
40 background search of [individuals who have direct access] (1) any

41 individual (A) to whom a long-term care facility will extend an offer of
42 employment, or (B) with whom a long-term care facility will enter into
43 a contract for the provision of long-term care services, and (2) any
44 volunteer who a long-term care facility reasonably expects will
45 regularly perform duties that are substantially similar to those of an
46 employee with direct access.

47 (c) (1) Except as provided in subdivision (2) of this subsection, each
48 long-term care facility, prior to extending an offer of employment to, or
49 entering into a contract for, the provision of long-term care services with
50 any individual, [who will have direct access,] or prior to allowing any
51 individual to begin volunteering at such long-term care facility when
52 the long-term care facility reasonably expects such volunteer will
53 regularly perform duties that are substantially similar to those of an
54 employee with direct access, shall require that such individual submit
55 to a background search. The Department of Public Health shall
56 prescribe the manner by which (A) long-term care facilities perform the
57 review of (i) the registry of nurse's aides maintained by the department
58 pursuant to section 20-102bb, and (ii) any other registry specified by the
59 department, including requiring long-term care facilities to report the
60 results of such review to the department, and (B) individuals submit to
61 state and national criminal history records checks, including requiring
62 the Department of Emergency Services and Public Protection to report
63 the results of such checks to the Department of Public Health.

64 (2) No long-term care facility shall be required to comply with the
65 provisions of this subsection if (A) the individual provides evidence to
66 the long-term care facility that such individual submitted to a
67 background search conducted pursuant to subdivision (1) of this
68 subsection not more than three years immediately preceding the date
69 such individual applies for employment, seeks to enter into a contract
70 or begins volunteering with the long-term care facility and that the prior
71 background search confirmed that the individual did not have a
72 disqualifying offense, or (B) the commissioner determines the need to
73 temporarily suspend the requirements of this subsection in the event of
74 an emergency or significant disruption. The commissioner shall inform

75 the long-term care facility when the commissioner has suspended the
76 requirements of this subsection pursuant to subparagraph (B) of this
77 subdivision and when such suspension is rescinded.

78 Sec. 2. (NEW) (*Effective October 1, 2025*) (a) There is established an
79 Alzheimer's Disease and Dementia task force. The task force shall:

80 (1) Examine (A) the needs of persons living with Alzheimer's disease
81 or dementia in the state, (B) the services available to such persons and
82 their family caregivers, and (C) the ability of health care providers and
83 institutions to meet the needs of such persons; and

84 (2) Develop a State Alzheimer's Plan, which shall make findings and
85 recommendations regarding:

86 (A) State residents living with Alzheimer's disease and dementia and
87 their service needs, including, but not limited to, (i) the state's role in
88 providing or facilitating long-term care, family caregiver support and
89 assistance to persons with early-stage and early-onset Alzheimer's
90 disease or dementia, (ii) state policies regarding persons living with
91 Alzheimer's disease or dementia, and (iii) the fiscal impact of
92 Alzheimer's disease and dementia on publicly funded health care
93 programs;

94 (B) Existing resources, services and capacity relating to the diagnosis
95 and care of persons living with Alzheimer's disease or dementia,
96 including, but not limited to, (i) the type, cost and availability of
97 dementia care services, (ii) the availability of health care providers who
98 can provide Alzheimer's disease or dementia-related services,
99 including, but not limited to, neurologists, geriatricians and direct care
100 workers, (iii) dementia-specific training requirements for public and
101 private employees who interact with persons living with Alzheimer's
102 disease or dementia, including, but not limited to, long-term care
103 providers, case managers, adult protective services employees and law
104 enforcement personnel and other first responders, (iv) home and
105 community-based services, including, but not limited to, respite care
106 services, (v) quality of care measures for home and community-based

107 services and residential care facilities, and (vi) state-supported
108 Alzheimer's disease and dementia research conducted at higher
109 education institutions located in the state; and

110 (C) Policies and strategies that (i) increase public awareness of
111 Alzheimer's disease and dementia, (ii) educate health care providers to
112 increase early detection and diagnosis of Alzheimer's disease and
113 dementia, (iii) improve health care services for persons living with
114 Alzheimer's disease or dementia, (iv) evaluate the capacity of the health
115 care system in meeting the growing number and needs of persons living
116 with Alzheimer's disease or dementia, (v) increase the number of health
117 care providers available to treat the growing aging population and
118 populations living with Alzheimer's disease or dementia, (vi) improve
119 services provided in the home and community to delay and decrease
120 the need for institutionalized care for persons living with Alzheimer's
121 disease or dementia, (vii) improve long-term care services, including,
122 but not limited to, assisted living services for persons living with
123 Alzheimer's disease or dementia, (viii) assist unpaid Alzheimer's
124 disease and dementia caregivers, (ix) increase and improve research on
125 Alzheimer's disease and dementia, (x) promote activities to maintain
126 and improve brain health, (xi) improve data and information collection
127 relating to Alzheimer's disease and dementia and the public health
128 burdens associated with such diseases, (xii) improve public safety and
129 address the safety-related needs of persons living with Alzheimer's
130 disease or dementia, (xiii) address legal protections for, and legal issues
131 faced by, persons living with Alzheimer's disease or dementia, and (xiv)
132 improve methods through which the state evaluates and adopts policies
133 to assist persons living with Alzheimer's disease or dementia.

134 (b) The task force shall consist of the following members:

135 (1) Eleven members appointed by the Governor, (A) one of whom
136 shall be a person living with early-stage or early-onset Alzheimer's
137 disease or dementia, (B) one of whom shall be a family caregiver of a
138 person living with Alzheimer's disease or dementia, (C) one of whom
139 shall represent a municipality that provides services to senior citizens,

140 (D) one of whom shall represent home health care agencies, (E) two of
141 whom shall be health care providers with experience diagnosing and
142 treating Alzheimer's disease, (F) one of whom shall represent a national
143 organization that advocates on behalf of persons living with
144 Alzheimer's disease or dementia, (G) one of whom shall represent the
145 area agencies on aging, established pursuant to section 17a-850 of the
146 general statutes, (H) one of whom shall represent long-term care
147 facilities, (I) one of whom shall have expertise in aging policy issues, and
148 (J) one of whom shall represent homemaker-companion agencies;

149 (2) The Commissioner of Aging and Disability Services, or the
150 commissioner's designee;

151 (3) The Commissioner of Public Health, or the commissioner's
152 designee;

153 (4) The Commissioner of Social Services, or the commissioner's
154 designee; and

155 (5) The State Ombudsman, or the State Ombudsman's designee.

156 (c) All initial appointments to the task force shall be made not later
157 than January 1, 2026. Task force members first appointed pursuant to
158 subparagraphs (A) to (D), inclusive, of subdivision (1) of subsection (b)
159 of this section shall serve for a term of two years. Task force members
160 first appointed pursuant to subparagraphs (E) to (J), inclusive, of
161 subdivision (1) of subsection (b) of this section shall serve for a term of
162 three years. Any subsequent task force member appointed pursuant to
163 subdivision (1) of subsection (b) of this section shall serve for a term of
164 two years, or until such member's successor is appointed. If the
165 Governor determines that no suitable successor candidate exists to
166 appoint to the task force, the Governor may reappoint an existing task
167 force member for one two-year term.

168 (d) The Commissioner of Aging and Disability Services, or the
169 commissioner's designee, shall convene the first meeting of the task
170 force not later than thirty days after all task force members are

171 appointed. At such meeting, the members of the task force shall select a
172 chairperson and vice chairperson from among the members of the task
173 force. The chairperson and vice chairperson may serve in such roles not
174 more than two consecutive years. The task force shall meet not less than
175 once every calendar quarter.

176 (e) The administrative staff of the joint standing committee of the
177 General Assembly having cognizance of matters relating to aging shall
178 serve as administrative staff of the task force.

179 (f) Not later than January 1, 2027, and annually thereafter, the task
180 force shall submit a report on the State Alzheimer's Plan to the Governor
181 and, in accordance with the provisions of section 11-4a of the general
182 statutes, the joint standing committees of the General Assembly having
183 cognizance of matters relating to aging, public health and human
184 services. Such report shall include recommendations for the
185 implementation of the State Alzheimer's Plan and identify any barriers
186 to the implementation of such plan. The task force shall update the State
187 Alzheimer's Plan every four years.

188 Sec. 3. Section 19a-535a of the general statutes is repealed and the
189 following is substituted in lieu thereof (*Effective October 1, 2025*):

190 (a) As used in this section:

191 (1) "Facility" means a residential care home, as defined in section 19a-
192 490;

193 (2) "Emergency" means a situation in which a resident of a facility
194 presents an imminent danger to the resident's own health or safety, the
195 health or safety of another resident or the health or safety of an
196 employee or the owner of the facility;

197 (3) "Department" means the Department of Public Health; and

198 (4) "Commissioner" means the Commissioner of Public Health, or the
199 commissioner's designee.

200 (b) A facility shall permit each resident to remain in the facility, and
201 not transfer or discharge a resident [from the facility] unless (1) the
202 transfer or discharge is necessary to meet the resident's welfare and the
203 resident's welfare cannot be met in the facility, (2) the transfer or
204 discharge is appropriate because the resident's health has improved
205 sufficiently so the resident no longer needs the services provided by the
206 facility, (3) the health or safety of individuals in the facility is
207 endangered, (4) the resident has failed, after reasonable and appropriate
208 notice, to pay for a stay or a requested service at the facility, or (5) the
209 facility ceases to operate.

210 (c) In the case of an involuntary transfer or discharge, the facility
211 shall, in a form and manner prescribed by the commissioner, provide
212 written notice to the resident and, if known, the resident's legally liable
213 relative, guardian or conservator not less than thirty days prior to the
214 proposed transfer or discharge date, except when the facility has
215 requested an immediate transfer or discharge in accordance with
216 subsection [(e)] (f) of this section. Such notice shall include (1) the reason
217 for the transfer or discharge, (2) the effective date of the transfer or
218 discharge, (3) the location to which the resident will be transferred or
219 discharged, (4) the right of the resident to appeal a transfer or discharge
220 by the facility pursuant to subsection [(d)] (e) of this section, [and] (5)
221 the resident's right to represent himself or herself or be represented by
222 legal counsel, [. Such notice shall be in a form and manner prescribed by
223 the commissioner, as modified from time to time, and shall include the
224 name, mailing address and telephone number of the State Long-Term
225 Care Ombudsman and be sent by facsimile or electronic communication
226 to the Office of the Long-Term Care Ombudsman on the same day as
227 the notice is given to the resident] (6) the name, mailing address and
228 telephone number of the State Long-Term Care Ombudsman, and (7) an
229 attestation by the facility that such notice has been submitted to the
230 Internet web site portal maintained by the State Ombudsman in
231 accordance with subsection (h) of this section. Such notice shall be
232 submitted to the Internet web site portal maintained by the State
233 Ombudsman on the same day such notice is provided to the resident. If

234 the facility knows the resident has, or the facility alleges that the resident
235 has, a mental illness or an intellectual disability, the notice shall also
236 include the name, mailing address and telephone number of the entity
237 designated by the Governor in accordance with section 46a-10b to serve
238 as the Connecticut protection and advocacy system. If any information
239 provided in a notice provided pursuant to the provisions of this
240 subsection changes prior to effecting the transfer or discharge of a
241 resident, the facility shall update each recipient of the notice in writing
242 as soon as practicable once the updated information becomes available.
243 No resident shall be involuntarily transferred or discharged from a
244 facility if such transfer or discharge presents imminent danger of death
245 to the resident.

246 [(c)] (d) The facility shall be responsible for assisting the resident in
247 finding an alternative residence and, in providing such assistance, shall
248 consider the resident's proximity to family members and any other
249 known support networks. A discharge plan, prepared by the facility, in
250 a form and manner prescribed by the commissioner, as modified from
251 time to time, shall include the resident's individual needs and shall be
252 submitted to the resident not later than seven days after the notice of
253 transfer or discharge is issued to the resident. The facility shall submit
254 the discharge plan to the commissioner at or before the hearing held
255 pursuant to subsection [(d)] (e) of this section.

256 [(d)] (e) (1) A resident or the resident's legally liable relative, guardian
257 or conservator who has been notified by a facility, pursuant to
258 subsection [(b)] (c) of this section, that the resident will be transferred or
259 discharged from the facility may appeal such transfer or discharge to
260 the Commissioner of Public Health by filing a request for a hearing with
261 the commissioner (A) not later than ten days after the receipt of such
262 notice, or (B) if the facility updates the location to which the resident will
263 be transferred or discharged pursuant to subsection (c) of this section,
264 not later than ten days after the receipt of such update, provided any
265 involuntary transfer or discharge shall be stayed during such ten-day
266 period. Upon receipt of any such request, the commissioner shall hold a
267 hearing to determine whether the transfer or discharge is being effected

268 in accordance with this section. Such a hearing shall be held not later
269 than seven business days after the receipt of such request. The
270 commissioner shall issue a decision not later than twenty days after the
271 closing of the hearing record. The hearing shall be conducted in
272 accordance with chapter 54.

273 (2) Any involuntary transfer or discharge that is appealed under this
274 subsection shall be stayed pending a final determination by the
275 commissioner.

276 (3) The commissioner shall send a copy of the decision regarding a
277 transfer or discharge to the facility, the resident and the resident's legal
278 guardian, conservator or other authorized representative, if known, or
279 the resident's legally liable relative or other responsible party, and the
280 State Long-Term Care Ombudsman.

281 ~~[(e)]~~ (f) (1) In the case of an emergency, the facility may request that
282 the commissioner make a determination as to the need for an immediate
283 transfer or discharge of a resident by submitting a sworn affidavit
284 attesting to the basis for the emergency transfer or discharge. The facility
285 shall provide a copy of the request for an immediate transfer or
286 discharge and the notice described in subsection ~~[(b)]~~ (c) of this section
287 to the resident. After receipt of such request, the commissioner may
288 issue an order for the immediate temporary transfer or discharge of the
289 resident from the facility. The temporary order shall remain in place
290 until a final decision is issued by the commissioner, unless earlier
291 rescinded. The commissioner shall issue the determination as to the
292 need for an immediate transfer or discharge of a resident not later than
293 seven days after receipt of the request from the facility. A hearing shall
294 be held not later than seven business days after the date on which a
295 determination is issued pursuant to this section. The commissioner shall
296 issue a decision not later than twenty days after the date on which the
297 hearing record is closed. The hearing shall be conducted in accordance
298 with the provisions of chapter 54.

299 (2) The commissioner shall send a copy of the decision regarding an

300 emergency transfer or discharge to the facility, the resident and the
301 resident's legal guardian, conservator or other authorized
302 representative, if known, or the resident's legally liable relative or other
303 responsible party and the State Long-Term Care Ombudsman.

304 (3) If the commissioner determines, based upon the request, that an
305 emergency does not exist, the commissioner shall proceed with a
306 hearing in accordance with the provisions of subsection [(d)] (e) of this
307 section.

308 [(f)] (g) A facility or resident who is aggrieved by a final decision of
309 the commissioner may appeal to the Superior Court in accordance with
310 the provisions of chapter 54. Pursuant to subsection (f) of section 4-183,
311 the filing of an appeal to the Superior Court shall not, of itself, stay
312 enforcement of an agency decision. The Superior Court shall consider
313 an appeal from a decision of the commissioner pursuant to this section
314 as a privileged case in order to dispose of the case with the least possible
315 delay.

316 [(g) Not later than six months after May 23, 2022, a] (h) A facility shall
317 electronically report each involuntary transfer or discharge (1) in a
318 manner prescribed by the State Ombudsman, appointed pursuant to
319 section 17a-405, and (2) on an Internet web site portal maintained by the
320 State Ombudsman in accordance with patient privacy provisions of the
321 Health Insurance Portability and Accountability Act of 1996, P.L. 104-
322 191, as amended from time to time.

323 Sec. 4. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

324 (1) "Biomarker" means a characteristic, including, but not limited to,
325 a gene mutation or protein expression that can be objectively measured
326 and evaluated as an indicator of normal biological processes, pathogenic
327 processes or pharmacologic responses to a specific therapeutic
328 intervention for a disease or condition.

329 (2) "Biomarker testing" means the analysis of a patient's tissue, blood
330 or other biospecimen for the presence of a biomarker, including, but not

331 limited to, tests for a single substance, tests for multiple substances and
332 diseases or conditions. "Biomarker testing" does not include an
333 evaluation of how a patient feels, functions or survives.

334 (3) "Clinical utility" means the test result provides information that is
335 used in the formulation of a treatment or monitoring strategy that
336 informs a patient's outcome and impacts the clinical decision.

337 (4) "Nationally recognized clinical practice guidelines" means
338 evidence-based clinical practice guidelines informed by a systematic
339 review of evidence and an assessment of the benefits and risks of
340 alternative care options intended to optimize patient care developed by
341 independent organizations or medical professional societies utilizing
342 transparent methodologies and reporting structures and conflict-of-
343 interest policies.

344 (b) Each individual health insurance policy providing coverage of the
345 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
346 of the general statutes delivered, issued for delivery, renewed, amended
347 or continued in this state on or after January 1, 2026, shall provide
348 coverage for biomarker testing for the purpose of diagnosis, treatment,
349 appropriate management or ongoing monitoring of an insured's disease
350 or condition, provided such biomarker testing provides clinical utility
351 as demonstrated by medical and scientific evidence, including, but not
352 limited to, one or more of the following: (1) Approval or clearance of
353 such test by the federal Food and Drug Administration or
354 recommendations on labels of drugs approved by the federal Food and
355 Drug Administration to conduct such test, (2) national coverage
356 determinations or local coverage determinations for Medicare
357 Administrative Contractors by the Centers for Medicare and Medicaid
358 Services, or (3) nationally recognized clinical practice guidelines. Such
359 policy shall provide such coverage in a manner that limits disruptions
360 in care, including, but not limited to, the need for multiple biopsies or
361 biospecimen samples. Such policy may require that biomarker testing
362 be performed at an in-network clinical laboratory, as defined in section
363 19a-490 of the general statutes.

364 (c) Each entity providing such coverage shall establish a clear, readily
365 accessible and convenient process through which an insured or an
366 insured's health care provider may (1) request an exception to a
367 coverage policy, or (2) dispute an adverse utilization review
368 determination relating to such coverage. Each such entity shall post
369 such process on the Internet web site maintained by such entity.

370 (d) If prior authorization is required before providing such coverage,
371 each entity providing such coverage or each utilization review entity or
372 other third party acting on behalf of such entity shall approve or deny
373 such prior authorization and notify the insured, the insured's health care
374 provider and any other entity requesting such prior authorization of
375 such approval or denial (1) if the prior authorization is not urgent, as
376 determined by the insured's health care provider, not later than seven
377 days after receiving a prior authorization request, or (2) if the prior
378 authorization is urgent, as determined by the insured's health care
379 provider, not later than seventy-two hours after receiving a prior
380 authorization request.

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

382 (1) "Biomarker" means a characteristic, including, but not limited to,
383 a gene mutation or protein expression that can be objectively measured
384 and evaluated as an indicator of normal biological processes, pathogenic
385 processes or pharmacologic responses to a specific therapeutic
386 intervention for a disease or condition.

387 (2) "Biomarker testing" means the analysis of a patient's tissue, blood
388 or other biospecimen for the presence of a biomarker, including, but not
389 limited to, tests for a single substance, tests for multiple substances and
390 diseases or conditions. "Biomarker testing" does not include an
391 evaluation of how a patient feels, functions or survives.

392 (3) "Clinical utility" means the test result provides information that is
393 used in the formulation of a treatment or monitoring strategy that
394 informs a patient's outcome and impacts the clinical decision.

395 (4) "Nationally recognized clinical practice guidelines" means
396 evidence-based clinical practice guidelines informed by a systematic
397 review of evidence and an assessment of the benefits and risks of
398 alternative care options intended to optimize patient care developed by
399 independent organizations or medical professional societies utilizing
400 transparent methodologies and reporting structures and conflict-of-
401 interest policies.

402 (b) Each group health insurance policy providing coverage of the
403 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
404 of the general statutes delivered, issued for delivery, renewed, amended
405 or continued in this state on or after January 1, 2026, shall provide
406 coverage for biomarker testing for the purpose of diagnosis, treatment,
407 appropriate management or ongoing monitoring of an insured's disease
408 or condition, provided such biomarker testing provides clinical utility
409 as demonstrated by medical and scientific evidence, including, but not
410 limited to, one or more of the following: (1) Approval or clearance of
411 such test by the federal Food and Drug Administration or
412 recommendations on labels of drugs approved by the federal Food and
413 Drug Administration to conduct such test, (2) national coverage
414 determinations or local coverage determinations for Medicare
415 Administrative Contractors by the Centers for Medicare and Medicaid
416 Services, or (3) nationally recognized clinical practice guidelines. Such
417 policy shall provide such coverage in a manner that limits disruptions
418 in care, including, but not limited to, the need for multiple biopsies or
419 biospecimen samples. Such policy may require that biomarker testing
420 be performed at an in-network clinical laboratory, as defined in section
421 19a-490 of the general statutes.

422 (c) Each entity providing such coverage shall establish a clear, readily
423 accessible and convenient process through which an insured or an
424 insured's health care provider may (1) request an exception to a
425 coverage policy, or (2) dispute an adverse utilization review
426 determination relating to such coverage. Each such entity shall post
427 such process on the Internet web site maintained by such entity.

428 (d) If prior authorization is required before providing such coverage,
429 each entity providing such coverage or each utilization review entity or
430 other third party acting on behalf of such entity shall approve or deny
431 such prior authorization and notify the insured, the insured's health care
432 provider and any other entity requesting such prior authorization of
433 such approval or denial (1) if the prior authorization is not urgent, as
434 determined by the insured's health care provider, not later than seven
435 days after receiving a prior authorization request, or (2) if the prior
436 authorization is urgent, as determined by the insured's health care
437 provider, not later than seventy-two hours after receiving a prior
438 authorization request.

439 Sec. 6. Subsection (d) of section 10a-77 of the general statutes is
440 repealed and the following is substituted in lieu thereof (*Effective from*
441 *passage*):

442 (d) Said board of trustees shall waive the payment of tuition at any of
443 the regional community-technical colleges (1) for any dependent child
444 of a person whom the armed forces of the United States has declared to
445 be missing in action or to have been a prisoner of war while serving in
446 such armed forces after January 1, 1960, which child has been accepted
447 for admission to such institution and is a resident of the state at the time
448 such child is accepted for admission to such institution, (2) subject to the
449 provisions of subsection (e) of this section, for any veteran, as defined in
450 section 27-103, who performed service in time of war, as defined in
451 section 27-103, except that for purposes of this subsection, "service in
452 time of war" shall not include time spent in attendance at a military
453 service academy, which veteran has been accepted for admission to such
454 institution and is domiciled in this state at the time such veteran is
455 accepted for admission to such institution, (3) for any resident of the
456 state (A) sixty-two years of age or older, or (B) who is a resident of a
457 nursing home, as defined in section 19a-490, and has maintained
458 residency at such nursing home for not less than thirty days, provided,
459 at the end of the regular registration period, there are enrolled in the
460 course a sufficient number of students other than those residents eligible
461 for waivers pursuant to this subdivision to offer the course in which

462 such resident intends to enroll and there is space available in such
463 course after accommodating all such students, (4) for any student
464 attending the Connecticut State Police Academy who is enrolled in a law
465 enforcement program at said academy offered in coordination with a
466 regional community-technical college which accredits courses taken in
467 such program, (5) for any active member of the Connecticut Army or
468 Air National Guard who (A) has been certified by the Adjutant General
469 or such Adjutant General's designee as a member in good standing of
470 the guard, and (B) is enrolled or accepted for admission to such
471 institution on a full-time or part-time basis in an undergraduate degree-
472 granting program, (6) for any dependent child of a (A) police officer, as
473 defined in section 7-294a, or supernumerary or auxiliary police officer,
474 (B) firefighter, as defined in section 7-323j, or member of a volunteer fire
475 company, (C) municipal employee, or (D) state employee, as defined in
476 section 5-154, killed in the line of duty, (7) for any resident of the state
477 who is a dependent child or surviving spouse of a specified terrorist
478 victim who was a resident of this state, (8) for any dependent child of a
479 resident of the state who was killed in a multivehicle crash at or near the
480 intersection of Routes 44 and 10 and Nod Road in Avon on July 29, 2005,
481 and (9) for any resident of the state who is a dependent child or
482 surviving spouse of a person who was killed in action while performing
483 active military duty with the armed forces of the United States on or
484 after September 11, 2001, and who was a resident of this state. If any
485 person who receives a tuition waiver in accordance with the provisions
486 of this subsection also receives educational reimbursement from an
487 employer, such waiver shall be reduced by the amount of such
488 educational reimbursement. Veterans and members of the National
489 Guard described in subdivision (5) of this subsection shall be given the
490 same status as students not receiving tuition waivers in registering for
491 courses at regional community-technical colleges. Notwithstanding the
492 provisions of section 10a-30, as used in this subsection, "domiciled in
493 this state" includes domicile for less than one year.

494 Sec. 7. Subsection (g) of section 19a-535 of the general statutes is
495 repealed and the following is substituted in lieu thereof (*Effective from*

496 *passage*):

497 (g) The facility shall be responsible for assisting the resident in
498 finding appropriate placement and, in providing such assistance, shall
499 consider the resident's proximity to family members and any other
500 known support networks.

501 Sec. 8. (*Effective from passage*) The State Ombudsman, in conjunction
502 with the Commissioners of Public Health and Social Services, shall
503 convene a working group to examine (1) residential care home
504 evacuation procedures, and (2) whether to require residential care
505 homes to participate in a mutual aid digital platform that supports the
506 risk management needs of health care organizations, including
507 dedicated solutions for emergency management, inspection, testing and
508 maintenance management, inspections management and health care
509 coalition management. The working group shall include not less than
510 two representatives of residential care homes. Not later than January 1,
511 2026, the working group shall submit a report, in accordance with the
512 provisions of section 11-4a of the general statutes, to the joint standing
513 committees of the General Assembly having cognizance of matters
514 relating to human services, public health and aging regarding the
515 findings and recommendations of the working group.

516 Sec. 9. Subsection (h) of section 19a-533 of the general statutes is
517 repealed and the following is substituted in lieu thereof (*Effective October*
518 *1, 2025*):

519 (h) Notwithstanding the provisions of this section, a nursing home
520 shall, without regard to the order of its waiting list, admit an applicant
521 who (1) seeks to transfer from a nursing home that is closing, [or] (2)
522 seeks to transfer from a nursing home in which the applicant was placed
523 following the closure of the nursing home where such applicant
524 previously resided or, in the case of a nursing home placed in
525 receivership, the anticipated closure of the nursing home where such
526 applicant previously resided, provided (A) the transfer occurs not later
527 than sixty days following the date that such applicant was transferred

528 from the nursing home where he or she previously resided, and (B)
 529 except when the nursing home that is closing transferred the resident
 530 due to an emergency, the applicant submitted an application to the
 531 nursing home to which he or she seeks admission at the time of the
 532 applicant's transfer from the nursing home where he or she previously
 533 resided, or (3) seeks to transfer from a nursing home that (A) has filed a
 534 certificate of need request pursuant to section 17b-352 on which the
 535 Commissioner of Social Services has not issued a final decision, and (B)
 536 has five residents or less. A nursing home that qualifies for a waiting list
 537 exemption pursuant to subsection (f) or (g) of this section shall not be
 538 required to admit an indigent person under this subsection except when
 539 the resident is being transferred from a nursing home that is closing due
 540 to an emergency. No nursing home shall be required to admit an
 541 applicant pursuant to the provisions of this subsection if the nursing
 542 home has determined that (i) the applicant does not have a payor source
 543 because the applicant has been denied Medicaid eligibility or the
 544 applicant has failed to pay a nursing home that is closing for the three
 545 months preceding the date of the application for admittance and has no
 546 pending application for Medicaid, (ii) the applicant is subject to a
 547 Medicaid penalty period, or (iii) the applicant does not require nursing
 548 home level of care as determined in accordance with applicable state
 549 and federal requirements.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2025	19a-491c(a) to (c)
Sec. 2	October 1, 2025	New section
Sec. 3	October 1, 2025	19a-535a
Sec. 4	January 1, 2026	New section
Sec. 5	January 1, 2026	New section
Sec. 6	from passage	10a-77(d)
Sec. 7	from passage	19a-535(g)
Sec. 8	from passage	New section
Sec. 9	October 1, 2025	19a-533(h)

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 \$	FY 27 \$
Resources of the General Fund	GF - Potential Revenue Gain	Minimal	Minimal
Department of Emergency Services and Public Protection	GF - Potential Cost	Minimal	Minimal
Department of Emergency Services and Public Protection	Applicant Fingerprint Card Submission Account - Potential Revenue Gain	Minimal	Minimal
State Comptroller - Fringe Benefits	GF - Potential Cost	Less than 100,000	Less than 200,000
Resources of the General Fund	GF - Potential Cost	Up to 92,000	Up to 184,000
Social Services, Dept.	GF - Potential Cost	See Below	See Below
Board of Regents for Higher Education	Other Fund - Potential Revenue Loss	Less than 100,000	Less than 100,000

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 26 \$	FY 27 \$
Various Municipalities	STATE MANDATE ¹ - Potential Cost	See Below	See Below
Various Municipal Police Departments	Potential Revenue Gain	Minimal	Minimal

¹ State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

Explanation

The bill contains various provisions, resulting in fiscal impacts as described by section below.

Section 1 requires all prospective employees and contractors of long-term care facilities to submit to fingerprint-based state criminal history records checks, resulting in: (1) a potential cost to the Department of Emergency Services and Public Protection (DESPP), (2) a potential revenue gain to the General Fund², and (3) a potential revenue gain to the Applicant Fingerprint Card Submission Account and various municipal police departments³ in FY 26 and FY 27. The potential cost to DESPP will depend on the extent to which the volume of new applicants for state criminal history checks increases department workload and impacts overtime. It is unknown how many employers already require such applicants to submit to such checks as a condition of employment.

There is no anticipated cost to the Department of Public Health as the existing long-term care background search program can accommodate any increase in background checks resulting from the bill.

Section 2 establishes an Alzheimer's Disease and Dementia task force, which does not result in a fiscal impact to the agencies involved in the task force's activities.

Section 3 makes procedural and technical changes to the existing process documenting involuntarily transfers or discharges from a residential care home (RCH), which have no fiscal impact.

Sections 4 and 5 mandate that certain health insurance plans provide

²DESPP conducts state criminal history records checks for a fee of \$75. The revenue that is collected from this fee is deposited into the General Fund.

³DESPP conducts fingerprinting for a fee of \$15 fee per person paid to the Applicant Fingerprint Card Submission Account. Municipal police departments may also conduct the required fingerprinting for state criminal history records checks and typically charge a fee of \$10 to \$15.

biomarker testing coverage, which results in multiple potential costs.

State Employee Health Plan. There is a potential cost of less than \$100,000 for the partial year coverage in FY 26 and less than \$200,000 annually thereafter to the State Comptroller – Fringe Benefits for the anticipated per member per month increase to the state employee health plan (SEHP) associated with the mandated coverage of biomarker testing. The SEHP currently covers biomarker testing. Premiums for the SEHP are anticipated to increase by \$0.10 per member per month, assuming a 5% utilization rate increase.

Municipalities. Costs related to the mandated coverage may also be incurred by fully insured municipalities and those participating in the State Partnership Plan (SPP). The mandated coverage of biomarker testing results in a potential cost less than \$34,000 for the partial year coverage in FY 26 and less than \$69,000 annually thereafter shared proportionately amongst municipalities in the SPP based on enrollment. The SPP currently covers biomarker testing. The potential cost accounts for an increase in utilization, and broader coverage for biomarker tests, which may impact plan premiums.

These estimates neglect any future cost saving offsets, and actual fiscal impacts will be realized in future premiums. Actual costs are dependent on the level of coverage, utilization, and number of those enrolled in each plan. Due to federal law, the coverage requirements will not apply to self-insured municipalities, as they are exempt under Employee Retirement Income Security Act (ERISA).

Exchange and Covered Connecticut. There is a potential cost to the state of up to \$92,000 for the partial year coverage in FY 26 and up to \$184,000 annually thereafter to defray additional premium costs for enrollees purchasing health insurance on the state's exchange. This cost is potential as it is incurred to the extent the new coverage requirements for biomarker testing are determined to increase premiums and constitute new state benefit mandates under the federal Affordable Care Act (ACA). Currently, the different plans in the exchange cover

biomarker testing. The potential cost accounts for an increase in utilization, and broader coverage for biomarker tests, which may impact plan premiums.

Under the ACA, states are allowed to mandate benefits beyond the federally-defined Essential Health Benefits (EHB) but must pay for that excess coverage. Federal regulations require the state to defray the cost of additional benefits related specific care, treatment or services mandated by state action after December 31, 2011 (except to comply with federal requirements) for all plans sold on the exchange.⁴ There are currently 152,042 enrollees in qualified health plans on the exchange, including approximately 42,000 in Covered Connecticut.

To the extent the bill is determined to include a new state benefit mandate that requires defrayal, there would be a cost to the state beginning January 1, 2026.⁵ Full year costs would begin in FY 27 and continue annually.

Defrayal costs for Covered Connecticut enrollees would be incurred by the Department of Social Services (DSS), to the extent the bill raises premiums for those enrollees.

Federal regulations allow states to update their EHB benchmark plans, potentially incorporating new benefit mandates without the need for defrayal for plan years beginning on January 1, 2020.⁶ If the state integrates biomarker testing into its EHB benchmark and obtains federal approval, these benefits become part of the EHB. As a result, the state would not be required to defray the costs of biomarker testing.

Section 6 results in a potential revenue loss of less than \$100,000 annually beginning in FY 26 to the Board of Regents for Higher Education. It waives tuition to CT State for nursing home residents who

⁴ 45 CFR 155.170

⁵ After determining if the mandate is subject to defrayal, states must reimburse the carriers or the insureds for the excess coverage. The premium costs are to be quantified by each insurer on the exchange and reported to the state.

⁶ 45 CFR 156.111

are enrolled in courses.

As of September 30, 2023, there were approximately 19,600 nursing home residents in Connecticut. Of this population, approximately 15% was under the age of 65. Current law waives tuition at CT State for state residents over the age of 62 under certain circumstances. For this reason, the number of people who receive the bill's waiver is expected to be minimal. If 10 people received a waiver at the FY 26 full-time, in-state tuition rate of \$4,608 for CT State, the revenue loss would be \$46,080. If those ten people instead each took one, three-credit course at the rate of \$576 for three credit hours, the revenue loss to CT State would be \$5,760.

Section 7, which requires nursing homes and residential care homes to consider a resident's proximity to family members and other known support networks when assisting with a transfer or discharge, does not result in a fiscal impact to the state.

Section 8, which establishes a working group to examine RCH evacuation procedures and participation in a mutual aid digital platform, does not result in a fiscal impact to the state. Workload adjustments can be managed within the current staffing levels of the specified state agencies.

Section 9 modifies criteria mandating nursing homes to disregard their waiting lists to admit an applicant, which has no state fiscal impact.

House "A" strikes the underlying bill and its associated fiscal impact, and results in the impact described above.

The Out Years

The annualized ongoing fiscal impact of Section 1 identified above would continue into the future subject to the number of state criminal history records checks performed.

The annualized ongoing fiscal impact of Sections 4 and 5 identified above would continue into the future subject to inflation, cost of biomarker tests, utilization of biomarker testing, and federal regulations

regarding defrayal requirements.

The annualized ongoing fiscal impact of Section 6 identified above would continue into the future subject to inflation in CT State tuition.

OLR Bill Analysis**sHB 6771 (as amended by House "A")*****AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR BIOMARKER TESTING.**

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Generally requires the Board of Trustees of the Community-Technical Colleges to waive tuition fees at any of the regional community-technical colleges for residents who, regardless of age, reside in a nursing home for at least 30 days

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Requires certain long-term care facilities to consider closeness to support networks when a resident is being transferred from a facility

§ 8 — RESIDENTIAL CARE HOME WORKING GROUP

Establishes a working group to examine topics related to residential care homes

§ 9 — WAITING LIST EXEMPTION

Adds to the circumstances when nursing homes generally must ignore their waiting list when admitting residents who are transferring from another nursing home

SUMMARY

This bill makes changes related to the regulation and oversight of long-term care and similar licensed facilities, establishes an aging-related task force and working group, requires certain health care insurers to cover biomarker testing, and allows certain nursing home residents to take courses at the regional community-technical colleges tuition free, as described in the section-by section analysis below.

The bill also makes technical and conforming changes.

*House Amendment "A" makes certain changes to the underlying provisions on insurance coverage for biomarker testing, such as (1) allowing policies to require that the testing be done at in-network clinical laboratories and (2) removing a provision that would have required a study by the insurance commissioner. It also adds the provisions on (1) background checks for all employees of long-term care facilities, (2) an Alzheimer's and dementia task force, (3) transfers and discharges from various long-term care facilities, (4) tuition waivers for nursing home residents, (5) a working group on residential care homes, and (6) nursing home waiting lists.

EFFECTIVE DATE: October 1, 2025, unless otherwise noted below.

§ 1 — LONG-TERM CARE FACILITY EMPLOYEE BACKGROUND CHECKS

Requires all prospective employees of long-term care facilities to undergo, or have had within three years, a criminal history and patient abuse background check

Existing law requires the Department of Public Health to implement a criminal history and patient abuse background search program for employees and volunteers at long-term care facilities.

The bill requires all prospective employees at these facilities (whether direct hires or contracted positions), not just those who will have direct access to patients or residents as under current law, to undergo a criminal history and patient abuse background check. It retains the existing requirement that volunteers have a background check if the facility reasonably expects their duties will be substantially similar to employees with direct access to patients or residents.

As under existing law, facilities do not have to require a background search for a prospective employee or volunteer if the person provides evidence that one occurred no more than three years immediately before applying for the position (and no disqualifying offense was revealed).

Background — Related Bill

sHB 6774 (File 24), favorably reported by the Aging Committee, similarly requires all prospective employees of long-term care facilities to undergo a criminal history and patient abuse background check.

§ 2 — ESTABLISHING AN ALZHEIMER'S DISEASE AND DEMENTIA TASK FORCE

Establishes a 15-member Alzheimer's Disease and Dementia Task Force and requires it to develop a State Alzheimer's Plan

The bill establishes an Alzheimer's Disease and Dementia Task Force. The task force must (1) examine the needs of people living with Alzheimer's or dementia, services available to them and their family caregivers, and health care providers' ability to meet the needs of people living with Alzheimer's or dementia and (2) develop a State Alzheimer's Plan.

The bill requires the task force to annually report, beginning by January 1, 2027, to the governor and the Aging, Human Services, and

Public Health committees. The report must include recommendations for implementing the State Alzheimer's Plan and identify any implementation barriers. The bill requires the task force to update the plan every four years.

State Alzheimer's Plan

Service Needs. The plan must include findings and recommendations about the service needs of people living with Alzheimer's and dementia including the following:

1. the state's role in providing or facilitating long-term care, family caregiver support, and assistance to people with early-stage and early-onset Alzheimer's or dementia;
2. state policies regarding people living with Alzheimer's or dementia; and
3. the fiscal impact of Alzheimer's and dementia on publicly funded health care programs.

Existing Resources. The plan must also make findings and recommendations about the existing resources, services, and capacity to deliver those to people living with Alzheimer's or dementia, including the following:

1. the type, cost, and availability of dementia care services;
2. the availability of health care providers who can provide Alzheimer's or dementia-related services (e.g., neurologists);
3. dementia-specific training requirements for public and private employees who interact with people living with Alzheimer's or dementia (e.g., long-term care providers and first responders);
4. home and community-based services, including respite care;
5. quality of care measures for home and community-based services and residential care facilities; and

6. state-supported Alzheimer's and dementia research conducted at higher education institutions in Connecticut.

Policies and Strategies. Lastly, the plan must make findings and recommendations about policies and strategies that do the following:

1. increase public awareness of Alzheimer's and dementia;
2. educate health care providers to increase early detection and diagnosis of these diseases;
3. improve health care services for people living with Alzheimer's and dementia;
4. evaluate the health care system's capacity to meet the growing number and needs of people living with Alzheimer's or dementia;
5. increase the number of health care providers available to treat the growing aging population and populations living with Alzheimer's or dementia;
6. improve services provided in the home and community to delay and decrease the need for institutionalized care for people living with these diseases;
7. improve long-term care services, including assisted living services for people living with Alzheimer's or dementia;
8. assist unpaid Alzheimer's and dementia caregivers;
9. increase and improve research on Alzheimer's and dementia;
10. promote activities to maintain and improve brain health;
11. improve data and information collection relating to Alzheimer's, dementia, and the public health burdens associated with these diseases;
12. improve public safety and address the safety-related needs of people living with Alzheimer's or dementia;

13. address legal protections for, and legal issues faced by, people living with these diseases; and
14. improve ways the state evaluates and adopts policies to assist people living with Alzheimer's or dementia.

Task Force Composition

Under the bill, the task force consists of 15 members, 11 of whom the governor must appoint. The 11 appointees must include the following:

1. a person living with early-stage or early-onset Alzheimer's or dementia;
2. a family caregiver of a person living with Alzheimer's or dementia;
3. a representative from a municipality that provides services to senior citizens;
4. a person representing home health care agencies;
5. two health care providers with experience diagnosing and treating Alzheimer's disease;
6. a person representing a national organization that advocates for people living with Alzheimer's or dementia;
7. a person representing the area agencies on aging;
8. a person representing long-term care facilities;
9. an expert in aging policy issues; and
10. a person representing homemaker-companion agencies.

The task force must also include the state ombudsman and the aging and disability services, public health, and social services commissioners, or their designees.

All initial task force appointments must be made by January 1, 2026,

and those initially appointed serve either a two- or three-year term as specified in the bill. Subsequent appointees must serve two-year terms. Members may be reappointed for an additional two-year term.

Task Force Organization

The aging and disability services commissioner, or her designee, must convene the first task force meeting within 30 days after all members are appointed. Task force members must select a chairperson and vice chairperson, from among the task force's members, to serve in those roles for up to two consecutive years. The task force must meet at least quarterly.

The Aging Committee's administrative staff serves as the task force's administrative staff.

Background — Related Bill

sHB 6912 (File 111), favorably reported by the Aging Committee, similarly establishes an Alzheimer's Disease and Dementia Task Force and requires the task force to develop a State Alzheimer's Plan.

§ 3 — TRANSFERS AND DISCHARGES IN RESIDENTIAL CARE HOMES

Adds to the information that residential care homes must include in the notice to residents before an involuntary transfer or discharge; requires these facilities to consider a resident's closeness to family and known support networks when helping residents find an alternative residence

Under existing law, if a residential care home involuntarily transfers or discharges a resident, the facility must give written notice to the resident and (if known) the resident's legally liable relative, guardian, or conservator. The facility must send the notice at least 30 days in advance except in an emergency.

The bill requires the written notice to include (1) the location to which the resident is being transferred or discharged and (2) an attestation by the facility that the notice was submitted to the Long-Term Care Ombudsman's website portal the same day it was given to the resident.

Under the bill, if the information in the written notice changes before

the transfer or discharge of the resident, the facility must update the notice as soon as practically possible.

The bill also requires residential care homes to consider a resident's proximity to family and known support networks when, as required by existing law, they help residents find a new appropriate placement when leaving or being transferred from the facility.

Appeals to Transfer or Discharge Decisions

Under existing law, a resident, or their legally liable relative, guardian, or conservator who has been notified by a facility that the resident will be transferred or discharged, may appeal the decision by filing a hearing request with the Department of Public Health commissioner within 10 days after the notice.

Under the bill, if the facility updates the location of where the resident will be transferred or discharged, any of these people may appeal the decision within 10 days after the updated notice. During those 10 days, the resident may not be involuntarily transferred or discharged to any location.

Background — Related Bill

HB 6972 (File 115), favorably reported by the Aging Committee, similarly adds to the information that residential care homes must include in their written notice before an involuntarily discharge or transfer and requires the notice to be updated as soon as practical if the information changes.

§§ 4 & 5 — HEALTH INSURANCE COVERAGE FOR BIOMARKER TESTING

Requires certain individual and group health insurance policies to cover biomarker testing to diagnose, treat, manage, or monitor an insured's disease or condition

The bill requires certain individual (§ 4) and group health insurance policies (§ 5) to cover biomarker testing to diagnose, treat, manage, or monitor an insured's disease or condition, if medical and scientific evidence (e.g., federal Food and Drug Administration approval, Medicare coverage determinations, or nationally recognized clinical

guidelines) shows the testing has clinical utility. The policies must provide coverage in a way that limits any disruptions to the insured's care. However, the policies may require that biomarker testing be done at an in-network clinical laboratory.

The bill also (1) requires health carriers to establish a process for insureds to request an exception to a coverage policy or dispute an adverse utilization review determination (e.g., denial) related to the coverage and (2) sets specific requirements for prior authorization requests.

Under the bill, a "biomarker" is a physical characteristic, including a gene mutation or protein expression that can be objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention for a disease or condition. "Biomarker testing" is the analysis of a patient's tissue, blood, or other biospecimen for a biomarker. Biomarker testing does not include an analysis of how a patient physically functions or feels.

EFFECTIVE DATE: January 1, 2026

Process for Policy Exceptions and Coverage Appeals

The bill requires each health carrier (e.g., insurer or HMO) to establish a clear, readily accessible, and convenient process through which an insured, or his or her health care provider, may request a coverage policy exception or dispute an adverse utilization review determination. Carriers must post these processes on their websites.

Prior Authorization Requests

Under the bill, if the health insurance policy requires an insured to receive prior authorization for biomarker testing, the health carrier, associated utilization review entity, or third party acting on the carrier's behalf must approve or deny the prior authorization request within specified deadlines. Specifically, it must notify the insured, his or her health care provider, or any entity requesting the prior authorization of

the approval or denial (1) within seven days, if the prior authorization is not urgent, or (2) within 72 hours if it is urgent. Under the bill, the health care provider determines if the authorization is urgent or not.

Bill Applicability

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

§ 6 — TUITION WAIVERS FOR NURSING HOME RESIDENTS

Generally requires the Board of Trustees of the Community-Technical Colleges to waive tuition fees at any of the regional community-technical colleges for residents who, regardless of age, reside in a nursing home for at least 30 days

The bill generally requires the Board of Trustees of the Community-Technical Colleges to waive tuition fees at any of the regional community-technical colleges for nursing home residents, regardless of age, who enroll in any course at these colleges. To qualify, nursing home residents must be a resident of the facility for at least 30 days. In addition, there must be enough other students enrolled in the course to offer it, and space available in the course after accommodating these other students.

Under existing law, state residents 62 years of age or older are eligible to have their tuition waived at the regional community-technical colleges if there are enough other students and space available after accommodating them.

EFFECTIVE DATE: Upon passage

Background — Related Bill

HB 7006 (File 118), favorably reported by the Aging; Higher Education and Employment Advancement; and Finance, Revenue and Bonding committees, requires the Board of Trustees of the Community-

Technical Colleges to waive tuition fees at any of the regional community-technical colleges for residents who, regardless of age, reside in a nursing home and enroll in online courses.

§ 7 — NURSING HOME TRANSFERS

Requires certain long-term care facilities to consider closeness to support networks when a resident is being transferred from a facility

The bill requires all Medicaid certified nursing facilities, Medicare certified skilled nursing facilities, and nursing homes to consider a resident's proximity to family and known support networks when, as required by existing law, they help residents find a new appropriate placement when leaving or being transferred from the facility.

EFFECTIVE DATE: Upon passage

§ 8 — RESIDENTIAL CARE HOME WORKING GROUP

Establishes a working group to examine topics related to residential care homes

The bill requires the state ombudsman, with the social services and public health commissioners, to convene a working group to examine (1) residential care home evacuation procedures and (2) if residential care homes should be required to use a mutual aid digital platform that supports the risk management needs of health care organizations, which includes dedicated solutions for:

1. emergency management,
2. inspections,
3. testing and maintenance management, and
4. health care coalition and inspections management.

The working group must include at least two people representing residential care homes and submit a report to the Aging, Human Services, and Public Health committees, by January 1, 2026, that contains the group's findings and recommendations.

EFFECTIVE DATE: Upon passage

§ 9 — WAITING LIST EXEMPTION

Adds to the circumstances when nursing homes generally must ignore their waiting list when admitting residents who are transferring from another nursing home

Existing law generally requires Medicaid-certified nursing homes to (1) admit residents on a first-come, first-served basis, regardless of their payment source and (2) keep waiting lists of and admit applicants in the order they are received, with certain exceptions (e.g., under certain conditions, when an applicant directly transfers from a home that is closing).

Under the bill, a nursing home generally must disregard its waiting list and admit an applicant who seeks to transfer from a nursing home that (1) has filed a certificate of need (CON) request (but before the social services commissioner makes a decision) and (2) has five residents or less.

But under the bill, nursing homes are not required to admit these applicants under certain circumstances, such as when the nursing home determines that the applicant does not (1) have a payor source because they have been denied Medicaid eligibility or (2) require a nursing home level of care according to law. The same exceptions apply under existing law for certain other transfers.

COMMITTEE ACTION

Aging Committee

Joint Favorable Substitute

Yea 13 Nay 0 (03/04/2025)

Insurance and Real Estate Committee

Joint Favorable

Yea 11 Nay 2 (04/01/2025)

Appropriations Committee

Joint Favorable

Yea 41 Nay 9 (05/05/2025)