PA 25-16—sHB 6771
Aging Committee
Insurance and Real Estate Committee
Appropriations Committee

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

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SUMMARY: This act 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 act also makes technical and conforming changes.

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

§ 1 — LONG-TERM CARE FACILITY EMPLOYEE BACKGROUND CHECKS

Generally requires all prospective employees of long-term care facilities to undergo a criminal history and patient abuse background check unless they had one done within three years

By law, the Department of Public Health (DPH) administers a criminal history and patient abuse background check program for employees and volunteers at long-term care facilities.

The act requires all prospective employees at these facilities (whether direct hires or contracted positions for long-term care services), not just those who will have direct access to patients or residents as under prior law, to undergo a criminal history and patient abuse background check under the program. 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 check 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).

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

The act 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 act 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 these diseases 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 and dementia and their associated public health burdens;
12. improve public safety and address the safety-related needs of people living with these diseases;
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 act, 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 long-term care 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 act. Subsequent appointees must serve two-year terms. Members may be reappointed for an additional two-year term if the governor determines that there is no suitable successor candidate.

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 themselves 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 must serve as the task force's administrative staff.

§ 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 send 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 act 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 (and the notice must be sent to the portal the same day it was given to the resident).

Under the act, if the information in the written notice changes before the resident's transfer or discharge, the facility must update the notice as soon as practically possible.

The act 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 DPH commissioner within 10 days after the notice.

Under the act, 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.

§§ 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 act requires certain individual and group health insurance policies 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 act 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 act, 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 act 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 act, 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 certain deadlines. Specifically, it must notify the insured, his or her health care provider, or any entity requesting the prior authorization about 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 act, the health care provider determines if the authorization is urgent or not.

Act Applicability

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2026, 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 act 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

§ 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 act 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 act 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, by January 1, 2026, submit a report on the group's findings and recommendations to the Aging, Human Services, and Public Health committees.

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 applicants and admit them 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 act, 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 act, 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.