General Assembly

Governor's Bill No. 5041

February Session, 2026

LCO No. **532**

Referred to Committee on HUMAN SERVICES

Introduced by:
Request of the Governor Pursuant
to Joint Rule 9

AN ACT EXPANDING HEALTH CARE COVERAGE.

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

Section 1. (*Effective from passage*) (a) As used in this section:

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and regulations adopted pursuant to said acts;

(2) "Connecticut Option program" means a standardized health benefit plan designed by the state to reduce health care coverage costs and made available through private or commercial insurance carriers to individuals in the state;

(3) "Exchange" means the Connecticut Health Insurance Exchange established under section 38a-1081 of the general statutes;

(4) "Health benefit plan" has the same meaning as provided in section 38a-1080 of the general statutes;

(5) "State innovation waiver" means a waiver of one or more requirements of the Affordable Care Act authorized under section 1332 of said act; and

(6) "Secretary" means the Secretary of the Office of Policy and Management.

(b) The Office of Policy and Management shall, within available resources, study the feasibility of establishing the Connecticut Option program with the goal of reducing health insurance premiums. The study shall include analyses, conclusions and recommendations sufficient for the secretary, in consultation with the Insurance Commissioner, to evaluate and compare design models. The study shall include, but need not be limited to:

(1) A review of the efficacy, impact and reasonableness of proposed program design elements, including, but not limited to: (A) Provider reimbursement methodologies; (B) value-based or performance-based contracting arrangements; (C) enrollee cost-sharing and premium affordability targets; (D) incentives or rewards for the delivery of high-quality, cost-effective health care; and (E) any state-specific premium assistance programs or risk stabilization programs, including, but not limited to, a state-operated reinsurance program that may maximize available federal funding pursuant to a state innovation waiver under Section 1332 of the Affordable Care Act;

(2) Identification of any necessary statutory or regulatory changes required for implementation;

(3) Determination of staffing needs across state agencies to effectively implement the Connecticut Option program;

(4) Analysis of the state insurance market and projected impacts of the Connecticut Option program on persons who receive health care coverage through the exchange; and

(5) Required state action or design elements needed to achieve multiple premium savings targets.

(c) Not later than January 15, 2027, the secretary shall file an interim report, in accordance with the provisions of section 11-4a of the general statutes, on the study conducted pursuant to subsection (b) of this section with the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services and insurance and real estate. Not later than January 31, 2028, the secretary shall file a final report, in accordance with the provisions of section 11-4a of the general statutes, on the feasibility of the Connecticut Option program and any recommendations on implementing the program with the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services and insurance and real estate.

(d) If the secretary, in consultation with the Insurance Commissioner, determines a Connecticut Option program is feasible after completion of the study or related reports pursuant to subsections (b) and (c) of this section, the secretary may direct the relevant state agency to develop and implement a waiver under Section 1332 of the Affordable Care Act or any applicable waiver from federal law that may be required to maximize federal funding for the program or any component part of a program design to help achieve health care savings.

Sec. 2. (NEW) (*Effective January 1, 2027*) As used in this section and section 3 of this act:

(1) "Biological product" has the same meaning as provided in 42 USC 262;

(2) "Biosimilar" means any biological product that is licensed under 42 USC 262(k);

(3) "Brand-name drug" means a drug that is produced or distributed

in accordance with an original new drug application approved under 21 USC 355, as amended from time to time, but does not include an authorized generic drug as defined in 42 CFR 447.502, as amended from time to time;

(4) "Formulary" means a list of prescription drugs that are covered by a specific health insurance plan;

(5) "Generic drug" means (A) a prescription drug product that is marketed or distributed in accordance with an abbreviated new drug application approved under 21 USC 355, as amended from time to time, (B) an authorized generic drug as defined in 42 CFR 447.502, as amended from time to time, or (C) a drug that entered the market before calendar year 1962 that was not originally marketed under a new prescription drug product application;

(6) "Reference product" means (A) with respect to a generic drug, the listed brand-name drug against which the generic drug is compared, in accordance with 21 USC 355(j)(2)(A)(i); and (B) with respect to a biosimilar, the reference biological product as defined in 42 USC 1395w-3a(c)(6)(I);

(7) "Wholesale acquisition cost" has the same meaning as provided in 42 USC 1395w-3a, as amended from time to time;

(8) "Health benefit plan" has the same meaning as provided in section 38a-1080 of the general statutes; and

(9) "Health carrier" has the same meaning as provided in section 38a-591a of the general statutes.

Sec. 3. (NEW) (*Effective January 1, 2027*) (a) If a generic drug (1) is approved by the United States Food and Drug Administration, (2) is marketed pursuant to such approval, and (3) has a wholesale acquisition cost that is less than the wholesale acquisition cost of the reference product on the generic drug's initial date of marketing, a health benefit

plan issued or renewed on or after January 1, 2027, that provides coverage for a reference product at the time of the generic drug's marketing date shall make the generic drug available on such health benefit plan's formulary with lower cost sharing, including actual out-of-pocket costs, relative to the reference product.

(b) If a biosimilar (1) is licensed by the United States Food and Drug Administration, (2) is marketed pursuant to such licensure, and (3) has a wholesale acquisition cost that is less than the wholesale acquisition cost of the reference product of such biosimilar on the initial date of marketing, a health benefit plan issued or renewed on or after January 1, 2027, that provides coverage for the biosimilar's reference product at the time of the biosimilar's marketing date shall make at least one biosimilar available on the formulary on a tier with lower cost sharing, including actual out-of-pocket costs, relative to the reference product.

(c) Subsections (a) and (b) of this section shall apply as long as the wholesale acquisition cost of the generic drug or biosimilar is lower than the wholesale acquisition cost of the reference product.

(d) A health benefit plan may not restrict the pharmacies through which enrollees may obtain the generic drug or biosimilar, unless the same restriction applies to the reference product.

(e) If a generic drug or biosimilar has a lower wholesale acquisition cost than its reference product, and neither the generic drug or biosimilar nor the reference product is included on the health benefit plan's formulary, the health benefit plan issued or renewed on or after January 1, 2027, shall not impose a more restrictive formulary exception process for the generic drug or biosimilar than for the reference product.

(f) Nothing in this section shall:

(1) Require a health benefit plan to provide coverage for a reference product after a generic drug or biosimilar is approved or licensed, as applicable, and marketed;

(2) Require a health benefit plan to provide coverage for a brand-name drug, biological product, generic drug or biosimilar if there is a determination by the pharmacy and therapeutics committee that develops the plan's formulary that such drug or biological product is no longer medically appropriate or cost-effective; or

(3) Interfere with the ability of a pharmacy or pharmacist to comply with the provisions of chapter 400j of the general statutes.

(g) The Insurance Commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

(h) The requirements of this section:

(1) Apply only with respect to coverage of and cost sharing for generic drugs, biosimilars and brand-name drugs when dispensed by pharmacies as outpatient prescription drugs and do not apply to generic drugs, biosimilars or brand-name drugs when provided by a hospital, physician or other provider of health care or palliative services, other than a pharmacy, incident to the services of such provider and paid for by or on behalf of the relevant health benefit plan as part of the payment for such services under the medical benefit of the health benefit plan;

(2) Do not apply to the extent that they would require coverage by a health benefit plan or enrollee cost sharing for a generic drug or biosimilar that is not permitted under any applicable federal law or any law of this state; and

(3) Do not require that a health benefit plan include on its formulary a generic drug or biosimilar if the health carrier has not included the reference product for that generic drug or biosimilar on its formulary due to a determination by the pharmacy and therapeutics committee for the health benefit plan that the brand-name drug should not be covered due to clinical concerns about the safety or efficacy of the brand-name drug based on the strength of scientific evidence.

Sec. 4. (NEW) (*Effective from passage and applicable to income and taxable years commencing on or after January 1, 2026*):

(a) As used in this section:

(1) "Commissioner" means the Commissioner of Revenue Services;

(2) "Department" means the Department of Revenue Services;

(3) "Income year" means the income year or taxable year, as determined under chapter 207, 208 or 229 of the general statutes, as the case may be;

(4) "Qualified small business" means an employer in the state that (A) is subject to tax under chapter 207, 208 or 229 of the general statutes, (B) employs fewer than fifty employees in the state on the date of its application under subsection (c) of this section, and (C) has adopted an individual coverage health reimbursement arrangement, as described in Section 9831(d) of the Internal Revenue Code, in lieu of a traditional employer-provided health insurance plan;

(5) "Qualified contribution" means a contribution by a qualified small business toward a covered employee's individual coverage health reimbursement arrangement during the income year; and

(6) "Covered employee" means an employee for whom the qualified small employer made a qualified contribution toward an individual coverage health reimbursement arrangement during the income year.

(b) (1) There is established an individual coverage health reimbursement arrangement tax credit for qualified small businesses whereby a qualified small business may be allowed a tax credit against the taxes imposed under chapter 207, 208 or 229 of the general statutes, other than the liability imposed by section 12-707 of the general statutes.

(2) The amount of the credit allowed for an income year shall be equal to the lesser of: (A) The sum of qualified contributions made by the

qualified small business during the income year, or (B) one thousand dollars per covered employee. Any tax credit not used in the income year during which it was earned shall expire and shall not be refundable.

(3) A credit under this section may be allowed to a qualified small business for the first income year during which the business offered an individual coverage health reimbursement arrangement and the immediately succeeding income year. No credit shall be allowed for any other income year.

(c) (1) Any qualified small business planning to claim a credit under the provisions of this section shall apply to the commissioner, in such form and manner prescribed by the commissioner, to reserve an allocation for a credit based upon the qualified contributions the business intends to make. Such application shall indicate the amount of qualified contributions that the business intends to make in the first income year during which it offers an individual coverage health reimbursement arrangement and the immediately succeeding income year. The application shall contain such information as the commissioner deems necessary to administer the provisions of this section.

(2) The commissioner shall approve applications for the reservation of a credit on a first-come, first-served basis and shall notify the qualified small business in writing not later than thirty days after the date of receipt of an application of the commissioner's approval or rejection of the application. If the commissioner approves the application of the qualified small business, the commissioner shall issue a certification letter indicating the amount of the tax credit that has been reserved for such business during each of the two income years for which it is eligible to claim the credit. A qualified small business may not claim a credit under this section in excess of the amount reserved by the commissioner.

(3) The total amount of tax credits reserved under this section shall not exceed five million dollars for any income year.

(d) If the qualified small business is an S corporation or an entity treated as a partnership for federal income tax purposes, the tax credit may be claimed by the shareholders or partners of the qualified small business. If the qualified small business is a single member limited liability company that is disregarded as an entity separate from its owner, the tax credit may be claimed by the limited liability company's owner.

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

(1) "Hiring party" means an entity who hires or enters into a contract with an eligible worker;

(2) "Eligible worker" means an individual whose compensation is reported or required to be reported on an Internal Revenue Service Form 1099 by a hiring party;

(3) "Portable benefit account" means an account owned by a person that is administered by a portable benefit account provider for the purposes of purchasing health insurance and health-related expenses by an eligible worker; and

(4) "Portable benefit account provider" means (A) a bank, (B) an investment management firm, or (C) a technology provider or program manager that offers services through a bank or investment management firm.

(b) Any hiring party may contribute to one or more portable benefit accounts as a form of compensation to an eligible worker.

(c) Making or receiving contributions to a portable benefit account shall not be used as a criterion for determining a worker's employment classification pursuant to any provision of the general statutes.

(d) Hiring parties may withhold a percentage of funds owed in compensation to an eligible worker for deposit into a portable benefit account if (1) withholding such compensation is agreed to in writing between the hiring party and the eligible worker; (2) the eligible worker voluntarily enters into such an arrangement; and (3) the written agreement clearly outlines the process to end the arrangement to withhold owed compensation to the eligible worker.

(e) At any time, an eligible worker may opt out of a compensation withholding arrangement by notifying the hiring party in writing. Hiring parties shall return all withheld compensation owed to any eligible worker not later than fifteen days after the hiring party is notified in writing of the eligible worker's decision to terminate the withholding arrangement.

Sec. 6. Section 19a-754c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For the purposes of this section:

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

(2) "Covered Connecticut program" means the program established under subsection (b) of this section;

(3) "Exchange" has the same meaning as provided in section 38a-1080;

(4) "Health carrier" has the same meaning as provided in section 38a-1080;

(5) "Individual market" has the same meaning as provided in 42 USC 18024(a), as amended from time to time; and

[(6) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a; and**]**

[(7)**]** (6) "Silver level" has the same meaning as provided in 42 USC 18022(d), as amended from time to time.

(b) There is established within the Department of Social Services the Covered Connecticut program for the purpose of reducing the state's uninsured rate. The Commissioner of Social Services shall administer said program in consultation with the **[**Office of Health Strategy,**]** Insurance Commissioner and exchange, and, as part of said program, the Department of Social Services shall:

(1) Provide premium and cost-sharing subsidies that are sufficient to ensure fully subsidized premium coverage:

(A) On and after July 1, 2021, for parents and needy caretaker relatives, and their tax dependents not older than twenty-six years of age, who (i) are eligible for premium and cost-sharing subsidies for a qualified health plan, (ii) are ineligible for Medicaid because their income exceeds the Medicaid income limits under chapter 319v, (iii) have household income up to one hundred seventy-five per cent of the federal poverty level, (iv) are receiving coverage under a qualified health plan offered through the exchange in the individual market at a silver level of coverage, and (v) are utilizing the full amount of applicable premium subsidies for such plan;

(B) On and after July 1, 2021, for the following additional family members of parents and caretaker relatives receiving coverage under such qualified health plan, provided the requirements of subparagraph (A) of subdivision (1) of this subsection are met: (i) A child over twenty-six years of age who is permanently and totally disabled, as defined by the Internal Revenue Service pursuant to 26 USC 152, or (ii) a child who is over the age of twenty-six and is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the parent or caretaker relative for support and maintenance, as described in sections 38a-489 and 38a-512a, or (iii) a child or stepchild receiving coverage under such qualified health plan

as described in sections 38a-497 and 38a-512b;

(C) On and after July 1, 2022, for all parents, needy caretaker relatives and low-income adults who (i) are at least nineteen but not more than sixty-four years of age, (ii) are eligible for premium and cost-sharing subsidies for a qualified health plan, (iii) are ineligible for Medicaid because their income exceeds the Medicaid income limits under chapter 319v, (iv) have household income up to one hundred seventy-five per cent of the federal poverty level, (v) are receiving coverage under a qualified health plan offered through the exchange in the individual market at a silver level of coverage, and (vi) are utilizing the full amount of applicable premium subsidies for such plan; and

(D) On and after July 1, 2022, for the following additional family members of parents, caretaker relatives, and adults receiving coverage under such qualified health plan, provided the requirements of subparagraph (C) of subdivision (1) of this subsection are met: (i) A child over twenty-six years of age who is permanently and totally disabled, as defined by the Internal Revenue Service pursuant to 26 USC 152, or (ii) a child who is over the age of twenty-six and is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the parent or caretaker relative for support and maintenance, as described in sections 38a-489 and 38a-512a, or (iii) a child or stepchild, as described in sections 38a-497 and 38a-512b.

[(2) Not earlier than July 1, 2022, provide dental and nonemergency medical transportation services, as provided under chapter 319v, to all eligible individuals described in subdivision (1) of this subsection;**]**

[(3)**]** (2) Establish procedures to, on a quarterly basis, pay in reimbursement to each health carrier offering the qualified health plan described in subparagraph (A) or (B) of subdivision (1) of this subsection, as applicable, the premium and cost-sharing subsidies required under subdivision (1) of this subsection to ensure fully subsidized coverage; and

[(4)**]** (3) Consult with the **[**Office of Health Strategy and**]** Insurance Commissioner for the purposes set forth in section 17b-312.

(c) On or after January 1, 2027, the Department of Social Services may, as part of the Covered Connecticut program, provide dental and nonemergency medical transportation services, as provided under chapter 319v, to all eligible individuals described in subsection (b) of this section;

[(c)**]** (d) (1) The **[**Office of Health Strategy**]** Department of Social Services may, subject to the approval required under subdivision (3) of this subsection, seek a waiver pursuant to Section 1332 of the Affordable Care Act, as amended from time to time, to advance the purpose of the Covered Connecticut program. The **[**Office of Health Strategy**]** department shall implement such waiver if the federal government issues such waiver.

(2) The **[**Office of Health Strategy**]** Department of Social Services shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, human services and insurance containing any proposed waiver described in subdivision (1) of this subsection before seeking such waiver from the federal government.

(3) Not later than thirty days after the **[**Office of Health Strategy**]** Department of Social Services submits a report under subdivision (2) of this subsection, the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, human services and insurance shall convene a joint public hearing on the proposed waiver contained in the report, **[**submitted pursuant to subdivision (2) of this subsection,**]** separately vote to approve or reject such proposed waiver and advise the **[**Office of Health Strategy**]** department of their approval or rejection of such proposed waiver. If any committee takes no action on such proposed waiver within the thirty-day period, the proposed waiver shall be deemed rejected.

[(d)**]** (e) The benefits and subsidies provided for individuals as part of the Covered Connecticut program shall not be considered income for such individuals for the purposes of chapter 229.

[(e) Not later than January 1, 2022, every six months thereafter through January 1, 2024, and annually after January 1, 2024, the**]** (f) The Commissioner of Social Services shall annually submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, human services and insurance. Such report shall contain a description of the operations and finances of, and progress made by, the Covered Connecticut program for the immediately preceding reporting period.

[(f) Notwithstanding any provision of this section**]** (g) On or before January 1, 2028, subject to federal approval, the Covered Connecticut program shall only include in-network health care providers and in-network services, unless the health carrier's network is deemed by the Insurance Commissioner to be inadequate. Benefits described in subsection (b) of this section and cost-sharing available to all eligible individuals pursuant to subdivision (1) of subsection (b) of this section shall only apply if such eligible individuals use in-network health care providers or in-network facilities.

(h) (1) Notwithstanding any provision of this section, the Commissioner of Social Services may make program design changes as necessary to meet requirements for approval, renewal or continuation of the federal waiver approved under Section 1115 of the Social Security Act pursuant to which the Covered Connecticut program is administered.

(2) The Commissioner of Social Services may, in consultation with the Office of Policy and Management, prior to the expiration of such federal waiver, explore, develop or pursue approval of alternative program designs, including, but not limited to, a basic health plan that enables

coverage for applicants with household incomes of up to two hundred per cent of the federal poverty level pursuant to Section 1331 of the Affordable Care Act, as amended from time to time.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*January 1, 2027*	New section
Sec. 3	*January 1, 2027*	New section
Sec. 4	*from passage and applicable to income and taxable years commencing on or after January 1, 2026*	New section
Sec. 5	*October 1, 2026*	New section
Sec. 6	*from passage*	19a-754c

Statement of Purpose:
To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]