General Assembly

Committee Bill No. 3

February Session, 2026

LCO No. **3126**

Referred to Committee on HUMAN SERVICES

Introduced by:
(HS)

AN ACT CONCERNING HEALTH CARE AFFORDABILITY.

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

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

9 (b) The amounts on deposit in said fund shall not constitute property
10 of the state and said fund shall not be construed to be a department,
11 institution or agency of the state. Amounts on deposit in said fund shall
12 not be commingled with state funds and the state shall have no claim to
13 or against, or any interest in, such deposits. Any contract entered into
14 by or any obligation of said fund shall not constitute a debt or obligation
15 of the state and the state shall have no obligation to any person on
16 account of said fund and all amounts obligated to be paid from said
17 fund shall be limited to amounts available for such obligation on deposit

18 in said fund. Said fund shall continue in existence as long as it holds any
19 deposits or has any obligations and until its existence is terminated by
20 law.

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

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

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

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

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

47 (4) Apply for and accept gifts, grants or donations from public or

48 private sources to enable said fund to carry out its objectives;

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

51 (6) Sue and be sued;

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

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

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

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

61 Sec. 2. Section 3-13c of the 2026 supplement to the general statutes is
62 repealed and the following is substituted in lieu thereof (*Effective July 1,*
63 *2026*):

64 As used in sections 3-13 to 3-13e, inclusive, and 3-31b, "trust funds"
65 includes the Connecticut Municipal Employees' Retirement Fund A, the
66 Connecticut Municipal Employees' Retirement Fund B, the Soldiers,
67 Sailors and Marines Fund, the Family and Medical Leave Insurance
68 Trust Fund, the State's Attorneys' Retirement Fund, the Teachers'
69 Annuity Fund, the Teachers' Pension Fund, the Teachers' Survivorship
70 and Dependency Fund, the School Fund, the State Employees
71 Retirement Fund, the Hospital Insurance Fund, the Policemen and
72 Firemen Survivor's Benefit Fund, any trust fund described in
73 subdivision (1) of subsection (b) of section 7-450 that is administered,
74 held or invested by the State Treasurer, the Connecticut Baby Bond
75 Trust, any Climate Change and Coastal Resiliency Reserve Fund created
76 pursuant to section 7-159d, the Early Childhood Education Endowment,

77 the Connecticut Affordable Health Care Trust Fund established
78 pursuant to section 1 of this act and all other trust funds administered,
79 held or invested by the State Treasurer.

80 Sec. 3. (*Effective July 1, 2026*) Notwithstanding the provisions of
81 sections 3 and 4 of special act 26-1, for the fiscal year ending June 30,
82 2027, the Secretary of the Office of Policy and Management shall transfer
83 two hundred million dollars from the Federal Cuts Response Fund,
84 established pursuant to section 1 of special act 26-1, to the Connecticut
85 Affordable Health Care Trust Fund established pursuant to section 1 of
86 this act.

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

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

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

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

103 (4) "Eligible enrollee" means a resident of the state who is eligible to
104 enroll in a qualified health plan on Access Health Connecticut and (A)
105 has household income not exceeding two hundred per cent of the
106 federal poverty level and is ineligible for the Covered Connecticut

107 program established pursuant to section 19a-754c of the general
108 statutes, or (B) has household income exceeding four hundred per cent
109 of the federal poverty level but not exceeding six hundred per cent of
110 the federal poverty level and is ineligible for federal premium subsidies
111 under the Affordable Care Act.

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

124 (c) The Connecticut Option program shall include a state health care
125 premium subsidy to enable an eligible enrollee to obtain an affordable
126 health plan on Access Health Connecticut for the period beginning July
127 1, 2026, and ending December 31, 2027. The program may include, but
128 shall not be limited to:

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

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

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

136 (d) In designing and implementing the Connecticut Option program,

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

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

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

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

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

167 Sec. 5. (NEW) (*Effective from passage*) (a) As used in this section and

168 section 6 of this act:

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

171 (2) "Eligible individual" means a state resident who (A) is under sixty-
172 five years of age, (B) has household income exceeding one hundred
173 thirty-three per cent of the federal poverty level but not exceeding two
174 hundred per cent of the federal poverty level, (C) is otherwise ineligible
175 for medical assistance programs established pursuant to chapter 319v of
176 the general statutes, and (D) is otherwise eligible to enroll in a qualified
177 health plan, as defined in section 38a-1080 of the general statutes, on
178 Access Health Connecticut, as defined in section 4 of this act; and

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

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

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

198 (d) If the commissioner determines that the cost of medical assistance
199 provided to eligible individuals in the basic health program will exceed
200 federal subsidies, or if changes in federal law, regulations or the
201 administration of federal law or regulations affects funding, eligibility
202 for or administration of the program, the commissioner, in consultation
203 with the Office of Policy and Management, may develop a plan to
204 respond to said changes. To the extent that federal funds received under
205 the Affordable Care Act for the basic health program exceed the cost of
206 medical assistance that would otherwise be provided to eligible
207 individuals, the commissioner shall use such funds to reduce the
208 premiums and cost-sharing of, or provide additional benefits for,
209 eligible individuals in accordance with 42 USC 18051, as amended from
210 time to time.

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

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

228 Sec. 6. (NEW) (*Effective October 1, 2026*) There is established an
229 account to be known as the "basic health program account", which shall

230 be a separate, nonlapsing account. The account shall contain any
231 moneys required by law to be deposited in the account. Moneys in the
232 account shall be expended by the Department of Social Services solely
233 for the purposes of operating a basic health program in accordance with
234 the Affordable Care Act.

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

240 (b) The working group shall consist of:

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

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

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

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

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

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

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

255 (8) The House and Senate chairpersons of the joint standing
256 committee of the General Assembly having cognizance of matters
257 relating to human services, who shall also serve as cochairpersons;

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

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

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

266 (12) Any other members the cochairpersons deem necessary.

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

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

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

284 (f) A majority of the membership of the working group shall
285 constitute a quorum for the transaction of any business and any decision
286 shall be by a majority vote of those present at a meeting, except the
287 cochairpersons may establish such committees, subcommittees or other

288 entities as they deem necessary to further the purposes of the working
289 group. The working group may adopt rules of procedure.

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

294 (h) Not later than December 1, 2026, the working group shall submit
295 a report to the joint standing committees of the General Assembly
296 having cognizance of matters relating to appropriations and the budgets
297 of state agencies, human services and insurance and real estate
298 concerning the groups' recommendations for the design and
299 implementation of the Connecticut Option program and the basic health
300 program. Such report shall contain a description of the programs,
301 including, but not limited to, operations and funding for the programs.

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

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

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

319 purchase.

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

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

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

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

346 [(e)] (f) Abandonment without cause by a spouse shall be a defense
347 to any liability pursuant to the provisions of subdivisions (1) to (4),
348 inclusive, of subsection (b) of this section for expenses incurred by and
349 for the benefit of such spouse. Nothing in this subsection shall affect the

350 duty of a parent to support his or her minor child.

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

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

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

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

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

379 (b) A hospital may opt in to the hospital financial assistance program

380 and be reimbursed pursuant to section 11 of this act. A participating
381 hospital shall not (1) count a patient's assets when determining
382 eligibility for hospital financial assistance, or (2) require the patient to
383 provide proof of a denial letter from the state medical assistance
384 program, Medicare, Emergency Medicaid, other government-funded
385 coverage or insurance through the Connecticut Health Insurance
386 Exchange. A hospital shall use software that conforms to industry
387 standards concerning electronic income verification and may accept one
388 of the following documents to verify income:

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

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

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

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

394 (c) A participating hospital shall exempt patients who are
395 experiencing homelessness or are at imminent risk of homelessness
396 from the documentation requirements but may require self-attested
397 information for both a hospital financial assistance screening and
398 hospital financial assistance application.

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

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

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

421 (c) A hospital aggrieved by a final decision of the commissioner on
422 the validity of such hospital's bills for hospital financial assistance may
423 file an appeal in accordance with the provisions of section 17b-60 of the
424 general statutes.

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

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

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

437 (2) The Commissioners of Social Services, Revenue Services, Mental
438 Health and Addiction Services, Developmental Services and Public
439 Health, the Insurance Commissioner and the Labor Commissioner, or

440 their designees;

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

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

452 (5) The chief executive officer of Access Health Connecticut, as
453 defined in section 4 of this act;

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

456 (7) Any other member that the cochairpersons deem necessary.

457 (c) The working group shall:

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

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

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

464 (4) Recommend budgetary, regulatory, administrative or legislative
465 measures to mitigate adverse procurement or service outcomes to the
466 Office of Policy and Management and the joint standing committees of
467 the General Assembly having cognizance of matters relating to

468 appropriations and the budgets of state agencies, human services,
469 housing and insurance and real estate; and

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

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

479 (1) An estimate of the number and percentage of Medicaid and
480 supplemental nutrition assistance program beneficiaries in the state
481 who may qualify for exemptions from work or community engagement
482 requirements imposed by the federal Fiscal Responsibility Act of 2023,
483 P.L. 118-5 and Section 71119 of P.L. 119-21;

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

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

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

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

496 (4) Recommendations for establishing a structured and sustainable

497 system to support interagency data sharing, beneficiary identification
498 and administrative practices that maximize the application of allowable
499 exemptions under federal law.

500 Sec. 13. (NEW) (*Effective from passage*) The Commissioner of Social
501 Services, in consultation with the Labor Commissioner, shall, not later
502 than thirty days after the effective date of this section, and monthly
503 thereafter, file a report, in accordance with the provisions of section 11-
504 4a of the general statutes, with the joint standing committee of the
505 General Assembly having cognizance of matters relating to human
506 services on:

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

510 (2) The number of beneficiaries who have lost and are expected to
511 lose eligibility for the programs since implementation of such
512 requirements under P.L. 119-21;

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

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

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

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

524 (7) Records related to how verification of compliance with the
525 requirements will be streamlined for recipients of supplemental

526 nutrition assistance and Medicaid;

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

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

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

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

538 (1) "HUSKY Health program" means the Medicaid and Children's
539 Health Insurance Program administered by the Department of Social
540 Services pursuant to sections 17b-261 and 17b-292 of the general statutes
541 and any related state plan amendments or waivers approved by the
542 federal Centers for Medicare and Medicaid Services.

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

547 (b) Whenever any federal statute, regulation, rule or administrative
548 guidance is enacted, adopted or issued that the Secretary of the Office
549 of Policy and Management, in consultation with the Commissioner of
550 Social Services, determines is likely to significantly affect federal
551 funding levels, program enrollment and eligibility requirements or
552 administrative operations of the HUSKY Health program or SNAP, the
553 secretary shall send written notice to the joint standing committees of
554 the General Assembly having cognizance of matters relating to
555 appropriations and the budgets of state agencies and human services.

556 The secretary shall include recommendations in the notice of statutes or
557 regulations that may need to be amended to preserve access to and
558 maximize the number of persons eligible for such programs.

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

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

570 (1) Determining whether an individual qualifies for an exemption
571 from work requirements under SNAP or from Medicaid community
572 engagement requirements, as defined in section 14 of this act;

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

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

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

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

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

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

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

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

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

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

610 (e) The department shall notify the joint standing committee of the
611 General Assembly having cognizance of matters relating to human
612 services in writing prior to disclosing any data pursuant to this section
613 and shall include in such notification where the department intends to
614 send the data and under what legal authority. All data use and data-

615 sharing activities conducted pursuant to this section shall comply with
616 all applicable state and federal laws governing confidentiality, privacy
617 and security, including, but not limited to:

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

620 (2) The Family Educational Rights and Privacy Act of 1974 (FERPA),
621 20 USC 1232g;

622 (3) 42 CFR Part 2, concerning the confidentiality of substance use
623 disorder treatment records;

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

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

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

628 (f) To the extent permissible under federal law, the Department of
629 Social Services may establish a system under which applicants and
630 beneficiaries of the HUSKY Health program and SNAP are asked, at the
631 time of application or renewal, to provide consent for the department to
632 access and use data maintained by other agencies in order to determine
633 or renew eligibility.

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

637 (1) The categories of data to be shared;

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

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

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

642 (h) To the extent permissible under federal law and within available
643 appropriations, the Department of Social Services may establish a
644 program whereby employers, nonprofits and other organizations as
645 identified in federal law, regulation or guidance may submit
646 information on behalf of their employees, clients, volunteers or other
647 related parties for the purposes of verifying whether an individual has
648 met work or community engagement requirements under the
649 supplemental nutrition assistance program or Medicaid in order to
650 facilitate enrollment and automatic renewal of eligibility.

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

656 (b) The commissioner shall take into consideration existing
657 definitions in state statutes and regulations relating to similar physical
658 conditions, definitions of medical frailty in other states, related medical
659 codes needed to diagnose such classification and ways to streamline
660 such classification across programs administered by the commissioner
661 that enroll medically frail individuals. The commissioner shall file a
662 report, in accordance with the provisions of section 11-4a of the general
663 statutes, not later than sixty days after the effective date of this section
664 with the joint standing committee of the General Assembly having
665 cognizance of matters relating to human services on a proposed
666 definition of medical frailty.

667 Sec. 17. (NEW) (*Effective July 1, 2026*) (a) The Commissioner of Social
668 Services shall submit any proposal to change the fee-for-service
669 Medicaid payment model to a managed care payment model to the joint
670 standing committees of the General Assembly having cognizance of
671 matters relating to human services and appropriations and the budgets
672 of state agencies for approval, denial or modification before

673 implementing such change or seeking any necessary federal approval to
674 implement such change. Not later than thirty days after the date of their
675 receipt of such proposal, such joint standing committees shall hold a
676 public hearing on the proposal. Not later than fifteen days before such
677 hearing, such joint standing committees shall inform the commissioner,
678 in writing, of the date and time of such hearing and invite the
679 commissioner to testify on the reasons for such proposal, including, but
680 not limited to, (1) any costs or benefits to the state, (2) the expected
681 impact on care provided to Medicaid recipients, and (3) the expected
682 impact on Medicaid reimbursements to providers of such care. At the
683 conclusion of such hearing, such joint standing committees shall vote on
684 whether to approve, deny or modify such proposal. The joint standing
685 committees shall advise the commissioner of their approval, denial or
686 modifications, if any, of the commissioner's proposal. If such joint
687 standing committees advise the commissioner of their denial, the
688 commissioner shall not implement the proposal or seek any necessary
689 federal approval to implement the proposal.

690 (b) If such joint standing committees do not concur, the committee
691 chairpersons shall appoint a committee of conference, which shall be
692 composed of three members from each joint standing committee. At
693 least one member appointed from each joint standing committee shall
694 be a member of the minority party. The report of the committee of
695 conference shall be made to each joint standing committee, which shall
696 vote to accept or reject the report. The report of the committee of
697 conference may not be amended. If one joint standing committee rejects
698 the report of the committee of conference, the proposal shall be deemed
699 denied. If such joint standing committees accept the report, the
700 committee having cognizance of matters relating to appropriations and
701 the budgets of state agencies shall advise the commissioner of their
702 approval, denial or modifications, if any, of the commissioner's
703 proposal. If such joint standing committees do not so advise the
704 commissioner during the thirty-day period, the proposal shall be
705 deemed denied.

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

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

723 (e) The commissioner shall include with any application for federal
724 approval of such proposal: (1) Any written comments received pursuant
725 to subsection (d) of this section; and (2) any additional written
726 comments submitted to such joint standing committees at such
727 proceedings. Such joint standing committees shall transmit any such
728 materials to the commissioner for inclusion with any such application
729 for federal approval.

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

732 (a) (1) Each health carrier shall maintain written procedures for (A)
733 utilization review and benefit determinations, (B) expedited utilization
734 review and benefit determinations with respect to prospective urgent
735 care requests and concurrent review urgent care requests, and (C)
736 notifying covered persons or covered persons' authorized
737 representatives of such review and benefit determinations. Each health

738 carrier shall make such review and benefit determinations within the
739 specified time periods under this section.

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

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

758 (B) After a health carrier notifies a covered person, a covered person's
759 authorized representative or a covered person's health care professional
760 of an initial adverse determination that was based, in whole or in part,
761 on medical necessity, of a concurrent or prospective utilization review
762 or of a benefit request, the health carrier shall offer a covered person's
763 health care professional the opportunity to confer, at the request of the
764 covered person's health care professional, with a clinical peer of such
765 health carrier, provided such covered person, covered person's
766 authorized representative or covered person's health care professional
767 has not filed a grievance of such initial adverse determination prior to
768 such conference. Such conference shall not be considered a grievance of
769 such initial adverse determination. Such health carrier shall grant such

770 clinical peer the authority to reverse such initial adverse determination.

771 (b) With respect to a nonurgent care request:

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

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

790 (C) If a health carrier notifies a covered person, authorized
791 representative or health care provider pursuant to subparagraph (B) of
792 this subdivision that additional information is necessary, the health
793 carrier shall approve or deny the prior authorization request not later
794 than twenty-four hours after receipt of such information.

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

799 (3) (A) The time period specified in subdivision (1) of this subsection

800 may be extended once by the health carrier for up to five calendar days,
801 and the time period specified in subdivision (2) of this subsection may
802 be extended once by the health carrier for up to fifteen calendar days,
803 provided the health carrier:

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

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

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

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

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

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

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

830 of the benefit requested.

831 (c) With respect to an urgent care request:

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

848 (B) Unless the covered person or the covered person's authorized
849 representative has failed to provide information necessary for the health
850 carrier to make a determination, for an urgent care request specified
851 under subparagraph (B) or (C) of subdivision (38) of section 38a-591a,
852 the health carrier shall make a determination as soon as possible, taking
853 into account the covered person's medical condition, but not later than
854 twenty-four hours after the health carrier receives such request,
855 provided, if the urgent care request is a concurrent review request to
856 extend a course of treatment beyond the initial period of time or the
857 number of treatments, such request is made not less than twenty-four
858 hours prior to the expiration of the prescribed period of time or number
859 of treatments.

860 (2) (A) If the covered person or the covered person's authorized
861 representative has failed to provide information necessary for the health

862 carrier to make a determination, the health carrier shall notify the
863 covered person or the covered person's representative, as applicable, as
864 soon as possible, but not later than twenty-four hours after the health
865 carrier receives such request. If a health carrier informs a covered
866 person, authorized representative or health care provider that
867 additional information is necessary for the health carrier to make a
868 determination on an urgent prior authorization request, the health
869 carrier shall approve or deny the request not later than twenty-four
870 hours after receipt of the necessary information.

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

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

884 (d) (1) If a health carrier fails, within the time periods specified in
885 subsections (b) and (c) of this section, to approve or deny a completed
886 prior authorization request, acknowledge receipt of the request or notify
887 the covered person, authorized representative or health care provider
888 that additional information is required, the prior authorization request
889 shall be deemed approved. Whenever a health carrier receives a review
890 request from a covered person or a covered person's authorized
891 representative that fails to meet the health carrier's filing procedures, the
892 health carrier shall notify the covered person and, if applicable, the
893 covered person's authorized representative of such failure not later than

894 five calendar days after the health carrier receives such request, except
895 that for an urgent care request, the health carrier shall notify the covered
896 person and, if applicable, the covered person's authorized
897 representative of such failure not later than twenty-four hours after the
898 health carrier receives such request. For a nonurgent prospective or
899 concurrent review request, each health carrier shall acknowledge receipt
900 of each such request as soon as practicable, but not later than twenty-
901 four hours after the health carrier receives such request, except that such
902 health carrier shall respond in less time if such a response is required by
903 applicable federal law.

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

913 (e) Any service for which prior authorization was required and
914 received, including deemed approvals, shall be paid in accordance with
915 state and federal prompt payment laws. A health carrier shall pay claims
916 for health care services for which prior authorization was required by
917 and received from the health carrier, including any prior authorization
918 deemed approved pursuant to subsection (d) of this section, except
919 where: (1) (A) The covered person was not eligible for coverage at the
920 time services were rendered; (B) benefits were exhausted; (C) the prior
921 authorization was based on materially inaccurate information provided
922 by the health care provider; (D) the health carrier has a reasonable belief
923 that fraud or intentional misconduct occurred; or (E) another health
924 carrier is responsible pursuant to coordination of benefits. Prior
925 authorization approval, whether express or deemed approved, shall
926 constitute a binding determination with respect to coverage and

927 payment. Each health carrier shall provide promptly to a covered
928 person and, if applicable, the covered person's authorized
929 representative a notice of an adverse determination.

930 [(1)] (2) Such notice may be provided in writing or by electronic
931 means and shall set forth, in a manner calculated to be understood by
932 the covered person or the covered person's authorized representative:

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

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

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

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

947 (E) A description of the health carrier's internal grievance process that
948 includes (i) the health carrier's expedited review procedures, (ii) any
949 time limits applicable to such process or procedures, (iii) the contact
950 information for the organizational unit designated to coordinate the
951 review on behalf of the health carrier, and (iv) a statement that the
952 covered person or, if applicable, the covered person's authorized
953 representative is entitled, pursuant to the requirements of the health
954 carrier's internal grievance process, to receive from the health carrier,
955 free of charge upon request, reasonable access to and copies of all
956 documents, records, communications and other information and

957 evidence regarding the covered person's benefit request;

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

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

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

982 (I) A statement, expressed in language approved by the Healthcare
983 Advocate and prominently displayed on the first page or cover sheet of
984 the notice using a call-out box and large or bold text, that if the covered
985 person or the covered person's authorized representative chooses to file
986 a grievance of an adverse determination, (i) such appeals are sometimes
987 successful, (ii) such covered person or covered person's authorized
988 representative may benefit from free assistance from the Office of the

989 Healthcare Advocate, which can assist such covered person or covered
990 person's authorized representative with the filing of a grievance
991 pursuant to 42 USC 300gg-93, as amended from time to time, (iii) such
992 covered person or covered person's authorized representative is entitled
993 and encouraged to submit supporting documentation for the health
994 carrier's consideration during the review of an adverse determination,
995 including narratives from such covered person or covered person's
996 authorized representative and letters and treatment notes from such
997 covered person's health care professional, and (iv) such covered person
998 or covered person's authorized representative has the right to ask such
999 covered person's health care professional for such letters or treatment
1000 notes.

1001 **[**(2)**]** (3) Upon request pursuant to subparagraph (E) of subdivision
1002 **[**(1)**]** (2) of this subsection, the health carrier shall provide such copies in
1003 accordance with subsection (a) of section 38a-591n.

1004 (f) If the adverse determination is a rescission, the health carrier shall
1005 include with the advance notice of the application for rescission
1006 required to be sent to the covered person, a written statement that
1007 includes:

1008 (1) Clear identification of the alleged fraudulent act, practice or
1009 omission or the intentional misrepresentation of material fact;

1010 (2) An explanation as to why the act, practice or omission was
1011 fraudulent or was an intentional misrepresentation of a material fact;

1012 (3) A disclosure that the covered person or the covered person's
1013 authorized representative may file immediately, without waiting for the
1014 date such advance notice of the proposed rescission ends, a grievance
1015 with the health carrier to request a review of the adverse determination
1016 to rescind coverage, pursuant to sections 38a-591e and 38a-591f;

1017 (4) A description of the health carrier's grievance procedures
1018 established under sections 38a-591e and 38a-591f, including any time

1019 limits applicable to those procedures; and

1020 (5) The date such advance notice of the proposed rescission ends and
1021 the date back to which the coverage will be retroactively rescinded.

1022 (g) (1) Whenever a health carrier fails to strictly adhere to the
1023 requirements of this section with respect to making utilization review
1024 and benefit determinations of a benefit request or claim, the covered
1025 person shall be deemed to have exhausted the internal grievance
1026 process of such health carrier and may file a request for an external
1027 review in accordance with the provisions of section 38a-591g, regardless
1028 of whether the health carrier asserts it substantially complied with the
1029 requirements of this section or that any error it committed was de
1030 minimis.

1031 (2) A covered person who has exhausted the internal grievance
1032 process of a health carrier may, in addition to filing a request for an
1033 external review, pursue any available remedies under state or federal
1034 law on the basis that the health carrier failed to provide a reasonable
1035 internal grievance process that would yield a decision on the merits of
1036 the claim.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2026*	New section
Sec. 2	*July 1, 2026*	3-13c
Sec. 3	*July 1, 2026*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*October 1, 2026*	New section
Sec. 7	*from passage*	New section
Sec. 8	*July 1, 2026*	New section
Sec. 9	*July 1, 2026*	46b-37
Sec. 10	*October 1, 2026*	New section
Sec. 11	*October 1, 2026*	New section
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	New section

Sec. 14	*from passage*	New section
Sec. 15	*from passage*	New section
Sec. 16	*from passage*	New section
Sec. 17	*July 1, 2026*	New section
Sec. 18	*January 1, 2027*	38a-591d

Statement of Purpose:

To support affordable health care in the state and mitigate the effects of federal cuts to health care premium subsidies.

[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.]

Co-Sponsors: SEN. LOONEY, 11th Dist.; SEN. DUFF, 25th Dist.
SEN. ANWAR, 3rd Dist.; SEN. CABRERA, 17th Dist.
SEN. COHEN, 12th Dist.; SEN. FLEXER, 29th Dist.
SEN. GADKAR-WILCOX, 22nd Dist.; SEN. GASTON, 23rd Dist.
SEN. HOCHADEL, 13th Dist.; SEN. HONIG, 8th Dist.
SEN. KUSHNER, 24th Dist.; SEN. LESSER, 9th Dist.
SEN. LOPES, 6th Dist.; SEN. MAHER, 26th Dist.
SEN. MARONEY, 14th Dist.; SEN. MARX, 20th Dist.
SEN. MCCRORY, 2nd Dist.; SEN. MILLER P., 27th Dist.
SEN. NEEDLEMAN, 33rd Dist.; SEN. RAHMAN, 4th Dist.
SEN. SLAP, 5th Dist.

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