Senate

General Assembly

File No. 735

January Session, 2023

Substitute Senate Bill No. 10

Senate, May 8, 2023

The Committee on Appropriations reported through SEN. OSTEN of the 19th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT PROMOTING ACCESS TO AFFORDABLE PRESCRIPTION DRUGS, HEALTH CARE COVERAGE, TRANSPARENCY IN HEALTH CARE COSTS, HOME AND COMMUNITY-BASED SUPPORT FOR VULNERABLE PERSONS AND RIGHTS REGARDING GENDER IDENTITY AND EXPRESSION.

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

Section 1. Subsection (d) of section 19a-754b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(d) (1) On or before March 1, 2020, and annually thereafter, the executive director of the Office of Health Strategy, in consultation with the Comptroller, Commissioner of Social Services and Commissioner of Public Health, shall prepare and make public a list of not more than ten outpatient prescription drugs that the executive director, in the executive director's discretion, determines are (A) provided at substantial cost to the state, considering the net cost of such drugs, or (B) critical to public health. The list shall include outpatient prescription drugs from different therapeutic classes of outpatient prescription

drugs and at least one generic outpatient prescription drug.

(2) **[**The executive director shall not list any outpatient prescription drug under subdivision (1) of this subsection unless the wholesale acquisition cost of the drug, less all rebates paid to the state for such drug during the immediately preceding calendar year, (A) increased by at least (i) twenty per cent during the immediately preceding calendar year, or (ii) fifty per cent during the immediately preceding three calendar years, and (B) was not less than sixty dollars for (i) a thirty-day supply of such drug, or (ii) a course of treatment of such drug lasting less than thirty days.**]** Prior to publishing the annual list of outpatient prescription drugs pursuant to subdivision (1) of this subsection, the executive director shall prepare a preliminary list of those outpatient prescription drugs that the executive director plans to include on the list. The executive director shall make the preliminary list available for public comment for not less than thirty days, during which time any manufacturer of an outpatient prescription drug named on the preliminary list may produce documentation to establish that the wholesale acquisition cost of the drug, less all rebates paid to the state for such drug during the immediately preceding calendar year, does not exceed the limits established in subdivision (3) of this subsection. If such documentation establishes, to the satisfaction of the executive director, that the wholesale acquisition cost, less all rebates paid to the state for such drug during the immediately preceding calendar year, does not exceed the limits established in subdivision (3) of this subsection, the executive director shall remove such drug from the list before publishing the final list. The executive director shall publish a final list pursuant to subdivision (1) of this subsection not later than fifteen days after the closing of the public comment period.

(3) The executive director shall not list any outpatient prescription drug under subdivision (1) or (2) of this subsection unless the wholesale acquisition cost of the drug, less all rebates paid to the state for such drug during the immediately preceding calendar year, (A) increased by at least sixteen per cent cumulatively during the immediately preceding two calendar years, and (B) was not less than forty dollars for a course

of therapy.

[(3)**]** (4) (A) The pharmaceutical manufacturer of an outpatient prescription drug included on a list prepared by the executive director pursuant to subdivision (1) of this subsection shall provide to the office, in a form and manner specified by the executive director, (i) a written, narrative description, suitable for public release, of all factors that caused the increase in the wholesale acquisition cost of the listed outpatient prescription drug, and (ii) aggregate, company-level research and development costs and such other capital expenditures that the executive director, in the executive director's discretion, deems relevant for the most recent year for which final audited data are available.

(B) The quality and types of information and data that a pharmaceutical manufacturer submits to the office under this subdivision shall be consistent with the quality and types of information and data that the pharmaceutical manufacturer includes in (i) such pharmaceutical manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K, or (ii) any other public disclosure.

[(4)**]** (5) The office shall establish a standardized form for reporting information and data pursuant to this subsection after consulting with pharmaceutical manufacturers. The form shall be designed to minimize the administrative burden and cost of reporting on the office and pharmaceutical manufacturers.

Sec. 2. (NEW) (*Effective January 1, 2024, and applicable to contracts entered into, amended or renewed on and after January 1, 2024*) (a) For the purposes of this section and sections 3 and 4 of this act:

(1) "Distributor" means any person or entity, including any wholesaler, who supplies drugs, devices or cosmetics prepared, produced or packaged by manufacturers, to other wholesalers, manufacturers, distributors, hospitals, clinics, practitioners or pharmacies or federal, state and municipal agencies;

(2) "Manufacturer" means the following:

(A) Any entity described in 42 USC 1396r-8(k)(5) that is subject to the pricing limitations set forth in 42 USC 256b; and

(B) Any wholesaler described in 42 USC 1396r-8(k)(11) engaged in the distribution of covered drugs for any entity described in 42 USC1396r-8(k)(5) that is subject to the pricing limitations set forth in 42 USC 256b;

(3) "ERISA plan" means an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974, as amended from time to time;

(4) (A) "Health benefit plan" means any insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in the state by a health carrier to provide, deliver, pay for or reimburse any of the costs of health care services;

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9), (14), (15) and (16) of section 38a-469 of the general statutes or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits

for health care services are secondary or incidental to other insurance benefits; and

(C) "Health benefit plan" does not include the following benefits if such benefits are provided under a separate insurance policy, certificate or contract or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof;

(iii) Other similar, limited benefits specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time;

(iv) Other supplemental coverage, similar to coverage of the type specified in subdivisions (9) and (14) of section 38a-469 of the general statutes, provided under a group health plan; or

(v) Coverage of the type specified in subdivision (3) or (13) of section 38a-469 of the general statutes or other fixed indemnity insurance if (I) such coverage is provided under a separate insurance policy, certificate or contract, (II) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (III) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

(5) "Maximum fair price" means the maximum rate for a prescription drug published by the Secretary of the United States Department of Health and Human Services under Section 1191 of the Inflation Reduction Act of 2022, P.L. 117-169, as amended from time to time. "Maximum fair price" does not include any dispensing fee paid to a pharmacy for dispensing any referenced drug;

(6) "Participating ERISA plan" means any employee welfare benefit

plan subject to the Employee Retirement Income Security Act of 1974, as amended from time to time, that elects to participate in the requirements pursuant to section 3 or 4 of this act;

(7) "Price applicability period" has the same meaning as provided in Section 1191 of the Inflation Reduction Act of 2022, P.L. 117-169, as amended from time to time;

(8) "Purchaser" means any state entity, health benefit plan or participating ERISA plan;

(9) "Referenced drug" means any prescription drug subject to the maximum fair price; and

(10) "State entity" means any agency of this state, including, any agent, vendor, fiscal agent, contractor or other person acting on behalf of this state, that purchases a prescription drug on behalf of this state for a person who maintains a health insurance policy that is paid for by this state, including health insurance coverage offered through local, state or federal agencies or through organizations licensed in this state. "State entity" does not include the medical assistance program administered under Title XIX of the Social Security Act, 42 USC 1396 et seq., as amended from time to time.

Sec. 3. (NEW) (*Effective January 1, 2024, and applicable to contracts entered into, amended or renewed on and after January 1, 2024*) (a) No purchaser shall purchase a referenced drug or seek reimbursement for a referenced drug to be dispensed, delivered or administered to an insured in this state, by hand delivery, mail or by other means, directly or through a distributor, for a cost that exceeds the maximum fair price during the price applicability period for such drug published pursuant to Section 1191 of the Inflation Reduction Act of 2022, P.L. 117-169, as amended from time to time.

(b) Each purchaser shall calculate such purchaser's savings generated pursuant to subsection (a) of this section and shall apply such savings to reduce prescription drug costs for the purchaser's insureds. Not later

than January fifteenth of each calendar year, a purchaser shall submit a report to the Insurance Department that (1) provides an assessment of such purchaser's savings for each referenced drug for the previous calendar year, and (2) identifies how each purchaser applied such savings to (A) reduce prescription drug costs for such purchaser's insureds, and (B) decrease cost disparities.

(c) An ERISA plan may elect to participate in the requirements of this section by notifying the Insurance Department, in writing, not later than January first of each calendar year.

(d) Any violation by a purchaser of subsection (a) of this section shall be subject to a civil penalty of one thousand dollars for each such violation.

(e) The Insurance Commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section and section 4 of this act.

Sec. 4. (NEW) (*Effective January 1, 2024, and applicable to contracts entered into, amended or renewed on and after January 1, 2024*) (a) No manufacturer or distributor of a referenced drug shall withdraw such referenced drug from sale or distribution in this state to attempt to avoid any loss of revenue resulting from the maximum fair price requirement established in section 3 of this act.

(b) Each manufacturer or distributor shall provide not less than one hundred eighty days' written notice to the Insurance Commissioner and Attorney General prior to withdrawing a referenced drug from sale or distribution in this state.

(c) If any manufacturer or distributor violates the provisions of subsection (a) or (b) of this section, such manufacturer or distributor shall be subject to a civil penalty of (1) five hundred thousand dollars, or (2) such purchaser's amount of annual savings generated pursuant to subsection (a) of section 3 of this act, as determined by the Insurance Commissioner, whichever is greater.

(d) It shall be a violation of this section for any manufacturer or distributor of a referenced drug to negotiate with a purchaser or seller of a referenced drug at a price that exceeds the maximum fair price.

(e) The Attorney General shall have exclusive authority to enforce violations of this section and section 3 of this act.

Sec. 5. (NEW) (*Effective July 1, 2023*) (a) As used in this section and section 6 of this act, (1) "federal 340B drug pricing program" means the plan described in Section 340B of the Public Health Service Act, 42 USC 256b, as amended from time to time, (2) "340B covered entity" means a provider participating in the federal 340B drug pricing program, (3) "prescription drug" has the same meaning as provided in section 19a-754b of the general statutes, and (4) "rebate" has the same meaning as provided in section 38a-479ooo of the general statutes.

(b) Not later than January fifteenth annually, a 340B covered entity shall provide a report to the executive director of the Office of Health Strategy, established pursuant to section 19a-754a of the general statutes, as amended by this act, providing, for the previous calendar year (1) a list of all prescription drugs, identified by the national drug code number, purchased through the federal 340B drug pricing program, (2) the actual purchase price of each such prescription drug after any rebate or discount provided pursuant to the program, (3) the actual payment each such 340B covered entity received from any private or public health insurance plan, except for Medicaid and Medicare, or patient for each such prescription drug, (4) the average percentage savings realized by each 340B covered entity on the cost of prescription drugs under the 340B program, and (5) how the 340B covered entity used prescription drug cost savings under the program. The executive director shall include a link to the report on the office's Internet web site.

Sec. 6. (NEW) (*Effective July 1, 2023*) No 340B covered entity shall attempt to collect as medical debt any payment for a prescription drug obtained with a rebate or at a discounted price through the federal 340B drug pricing program that exceeds the cost of such drug paid by such entity.

Sec. 7. (NEW) (*Effective July 1, 2023*) (a) There is established a Prescription Drug Payment Evaluation Committee to recommend upper payment limits on not fewer than eight prescription drugs to the executive director of the Office of Health Strategy based on evaluation of upper payment limits on such drugs set by other states or foreign jurisdictions.

(b) Members of the committee shall be as follows:

(1) Three appointed by the speaker of the House of Representatives, who shall be (A) a representative of a state-wide health care advocacy coalition, (B) a representative of a state-wide advocacy organization for elderly persons, and (C) a representative of a state-wide organization for diverse communities;

(2) Three appointed by the president pro tempore of the Senate, who shall be (A) a representative of a labor union, (B) a health services researcher, and (C) a consumer who has experienced barriers to obtaining prescription drugs due to the cost of such drugs;

(3) Two appointed by the majority leader of the House of Representatives, who shall be representatives of 340B covered entities, as defined in section 5 of this act;

(4) Two appointed by the minority leader of the House of Representatives, who shall be representatives of private insurers;

(5) Two appointed by the majority leader of the Senate, who shall be representatives of organizations representing health care providers;

(6) Two appointed by the minority leader of the Senate, who shall be (A) a representative of a pharmaceutical company doing business in the state, and (B) a representative of an academic institution with expertise in health care costs;

(7) Two appointed by the Governor, who shall be (A) a representative of pharmacists, and (B) a representative of pharmacy benefit managers;

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

(9) The Commissioner of Social Services, or the commissioner's designee;

(10) The Commissioner of Public Health, or the commissioner's designee;

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

(12) The Commissioner of Consumer Protection, or the commissioner's designee;

(13) The executive director of the Office of Health Strategy, or the executive director's designee; and

(14) The Healthcare Advocate, or the Healthcare Advocate's designee.

(c) All initial appointments to the committee shall be made not later than August 1, 2023. Any vacancy shall be filled by the appointing authority.

(d) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the committee from among the members of the committee. Such chairpersons shall schedule the first meeting of the committee, which shall be held not later than September 1, 2023.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the committee.

(f) Not later than December 1, 2023, and annually thereafter, the committee shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the executive director of the Office of Health Strategy and the joint standing committees of the General Assembly having cognizance of matters relating to

appropriations and the budgets of state agencies, human services, insurance and public health with its recommendations concerning upper payment limits for not fewer than eight prescription drugs.

Sec. 8. Section 3-112 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(a) The Comptroller shall: (1) Establish and maintain the accounts of the state government and perform such other duties as are prescribed by the Constitution of the state; (2) register all warrants or orders for the disbursement of the public money; (3) adjust and settle all demands against the state not first adjusted and settled by the General Assembly and give orders on the Treasurer for the balance found and allowed; (4) prescribe the mode of keeping and rendering all public accounts of departments or agencies of the state and of institutions supported by the state or receiving state aid by appropriation from the General Assembly; (5) prepare and issue effective accounting and payroll manuals for use by the various agencies of the state; (6) from time to time, examine and state the amount of all debts and credits of the state; present all claims in favor of the state against any bankrupt, insolvent debtor or deceased person; and institute and maintain suits, in the name of the state, against all persons who have received money or property belonging to the state and have not accounted for it; and (7) administer the Connecticut Retirement Security Program, established pursuant to section 31-418.

(b) All moneys recovered, procured or received for the state by the authority of the Comptroller shall be paid to the Treasurer, who shall file a duplicate receipt therefor with the Comptroller. The Comptroller may require reports from any department, agency or institution as aforesaid upon any matter of property or finance at any time and under such regulations as the Comptroller prescribes and shall require special reports upon request of the Governor, and the information contained in such special reports shall be transmitted by him to the Governor. All records, books and papers in any public office shall at all reasonable times be open to inspection by the Comptroller. The Comptroller may draw his order on the Treasurer for a petty cash fund for any budgeted

agency. Expenditures from such petty cash funds shall be subject to such procedures as the Comptroller establishes. In accordance with established procedures, the Comptroller may enter into such contractual agreements as may be necessary for the discharge of his duties. As used in this section, "adjust" means to determine the amount equitably due in respect to each item of each claim or demand.

(c) The Comptroller shall establish and administer a prescription drug discount card program available to all residents of the state. The Comptroller may coordinate participation in a multistate prescription drug consortium for the purposes of pooling prescription drug purchasing power to lower costs by negotiating discounts with prescription drug manufacturers and coordinating volume discount contracting.

Sec. 9. Section 38a-477g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

(a) As used in this section: **[**(1) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a, (2) "health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f.**]**

(1) "All-or-nothing clause" means a provision in a health care contract that:

(A) Requires the health insurance carrier or health plan administrator to include all members of a health care provider in a network plan; or

(B) Requires the health insurance carrier or health plan administrator to enter into any additional contract with an affiliate of the health care provider as a condition to entering into a contract with such health care provider.

(2) "Anti-steering clause" means a provision of a health care contract that restricts the ability of the health insurance carrier or health plan

administrator from encouraging an enrollee to obtain a health care service from a competitor of the hospital or health system, including offering incentives to encourage enrollees to utilize specific health care providers.

(3) "Anti-tiering clause" means a provision in a health care contract that:

(A) Restricts the ability of the health insurance carrier or health plan administrator to introduce and modify a tiered network plan or assign health care providers into tiers; or

(B) Requires the health insurance carrier or health plan administrator to place all members of a health care provider in the same tier of a tiered network plan.

(4) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a.

(5) "Health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa.

(6) "Health plan administrator" means a third-party administrator who acts on behalf of a plan sponsor to administer a health benefit plan.

(7) "Intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f.

(8) "Tiered network" has the same meaning as provided in section 38a-472f.

(9) "Value-based care" means a health care coverage model in which providers, including hospitals and physicians, are paid based on patient health outcomes.

(b) (1) Each contract entered into, renewed or amended on or after January 1, 2017, between a health carrier and a participating provider shall include:

(A) A hold harmless provision that specifies protections for covered persons. Such provision shall include the following statement or a substantially similar statement: "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.";

(B) A provision that in the event of a health carrier or intermediary insolvency or other cessation of operations, the participating provider's obligation to deliver covered health care services to covered persons without requesting payment from a covered person other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services will continue until the earlier of (i) the termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in subdivision (2) of subsection (g) of section 38a-472f, or are totally disabled, or (ii) the date the contract between the health carrier and the participating provider would have terminated if the health carrier or intermediary had remained in operation, including

any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled;

(C) (i) A provision that requires the participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons, and (ii) a statement that such participating provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person's right to view, obtain copies of or amend such covered person's medical and health records; and

(D) (i) If such contract is entered into, renewed or amended before July 1, 2022, definitions of what is considered timely notice and a material change for the purposes of subparagraph (A) of subdivision (2) of subsection (c) of this section, or (ii) if such contract is entered into, renewed or amended on or after July 1, 2022, (I) a statement disclosing the ninety-day advance written notice requirement established under subparagraph (B) of subdivision (2) of subsection (c) of this section and what is considered a material change for the purposes of subdivision (2) of subsection (c) of this section, and (II) provisions affording the participating provider a right to appeal any proposed change to the provisions, other documents, provider manuals or policies disclosed pursuant to subdivision (1) of subsection (c) of this section.

(2) The contract terms set forth in subparagraphs (A) and (B) of subdivision (1) of this subsection shall (A) be construed in favor of the covered person, (B) survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health carrier, and (C) supersede any oral or written agreement between a health care provider and a covered person or a covered person's authorized representative that is contrary to or inconsistent with the requirements set forth in subdivision (1) of this subsection.

(3) No contract subject to this subsection shall include any provision that conflicts with the provisions contained in the network plan or

required under this section, section 38a-472f or section 38a-477h.

(4) No health carrier or participating provider that is a party to a contract under this subsection shall assign or delegate any right or responsibility required under such contract without the prior written consent of the other party.

(c) (1) At the time a contract subject to subsection (b) of this section is signed, the health carrier or such health carrier's intermediary shall disclose to a participating provider:

(A) All provisions and other documents incorporated by reference in such contract; and

(B) If such contract is entered into, renewed or amended on or after July 1, 2022, all provider manuals and policies incorporated by reference in such contract, if any.

(2) While such contract is in force, the health carrier shall:

(A) If such contract is entered into, renewed or amended before July 1, 2022, timely notify a participating provider of any change to the provisions or other documents specified under subparagraph (A) of subdivision (1) of this subsection that will result in a material change to such contract; or

(B) If such contract is entered into, renewed or amended on or after July 1, 2022, provide to a participating provider at least ninety days' advance written notice of any change to the provisions or other documents specified under subparagraph (A) of subdivision (1) of this subsection, and any change to the provider manuals and policies specified under subparagraph (B) of subdivision (1) of this subsection, that will result in a material change to such contract or the procedures that a participating provider must follow pursuant to such contract.

(d) (1) (A) Each contract between a health carrier and an intermediary entered into, renewed or amended on or after January 1, 2017, shall satisfy the requirements of this subsection.

(B) Each intermediary and participating providers with whom such intermediary contracts shall comply with the applicable requirements of this subsection.

(2) No health carrier shall assign or delegate to an intermediary such health carrier's responsibilities to monitor the offering of covered benefits to covered persons. To the extent a health carrier assigns or delegates to an intermediary other responsibilities, such health carrier shall retain full responsibility for such intermediary's compliance with the requirements of this section.

(3) A health carrier shall have the right to approve or disapprove the participation status of a health care provider or facility in such health carrier's own or a contracted network that is subcontracted for the purpose of providing covered benefits to the health carrier's covered persons.

(4) A health carrier shall maintain at its principal place of business in this state copies of all intermediary subcontracts or ensure that such health carrier has access to all such subcontracts. Such health carrier shall have the right, upon twenty days' prior written notice, to make copies of any intermediary subcontracts to facilitate regulatory review.

(5) (A) Each intermediary shall, if applicable, (i) transmit to the health carrier documentation of health care services utilization and claims paid, and (ii) maintain at its principal place of business in this state, for a period of time prescribed by the commissioner, the books, records, financial information and documentation of health care services received by covered persons, in a manner that facilitates regulatory review, and shall allow the commissioner access to such books, records, financial information and documentation as necessary for the commissioner to determine compliance with this section and section 38a-472f.

(B) Each health carrier shall monitor the timeliness and appropriateness of payments made by its intermediary to participating providers and of health care services received by covered persons.

(6) In the event of the intermediary's insolvency, a health carrier shall have the right to require the assignment to the health carrier of the provisions of a participating provider's contract that address such participating provider's obligation to provide covered benefits. If a health carrier requires such assignment, such health carrier shall remain obligated to pay the participating provider for providing covered benefits under the same terms and conditions as the intermediary prior to the insolvency.

(e) The commissioner shall not act to arbitrate, mediate or settle (1) disputes regarding a health carrier's decision not to include a health care provider or facility in such health carrier's network or network plan, or (2) any other dispute between a health carrier, such health carrier's intermediary or one or more participating providers, that arises under or by reason of a participating provider contract or the termination of such contract.

(f) On and after January 1, 2024, no health insurance carrier, health care provider, health plan administrator or any agent or other entity that contracts on behalf of a health care provider, health insurance carrier or health plan administrator may offer, solicit, request, amend, renew or enter into a health care contract that would directly or indirectly include any of the following provisions:

(1) An all-or-nothing clause;

(2) An anti-steering clause;

(3) An anti-tiering clause; or

(4) Any other clause that results or intends to result in anticompetitive effects.

(g) On and after January 1, 2024, any contract, written policy, written procedure or agreement that contains a clause contrary to the provisions set forth in subsection (f) of this section shall be null and void. All remaining clauses of the contract shall remain in effect for the duration of the contract term.

(h) Nothing in this section shall be construed to prohibit value-based care.

(i) The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of subsection (f) of this section.

Sec. 10. Subsection (a) of section 17b-242 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to home health care agencies and home health aide agencies in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year. The commissioner shall include in the fee schedule not less than two licensed clinical social worker visits to each individual enrolled in the Connecticut home-care program for the elderly or any home and community-based Medicaid waiver program administered by the Department of Social Services. The commissioner may increase any fee payable to a home health care agency or home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; (3) escort services; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or home health aide agency which,

due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after the date of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months.

Sec. 11. (NEW) (*Effective from passage*) (a) For purposes of this section, "certified community health worker" has the same meaning as provided in section 20-195ttt of the general statutes. The Commissioner of Social Services shall design and implement a program to provide Medicaid reimbursement to certified community health workers for services provided to HUSKY Health program members, including, but not limited to: (1) Coordination of medical, oral and behavioral health care services and social supports; (2) connection to and navigation of health systems and services; (3) prenatal, birth, lactation and postpartum supports; and (4) health promotion, coaching and self-management education.

(b) The commissioner shall provide reimbursement for the services of certified community health workers in a manner and at a rate conducive to workforce growth.

(c) The commissioner and the commissioner's designees shall consult with certified community health workers and others throughout the design and implementation of the certified community health worker reimbursement program in a manner that (1) is inclusive of community-

based and clinic-based certified community health workers; (2) is representative of medical assistance program member demographics; and (3) helps shape the reimbursement program's design and implementation.

(d) The Department of Social Services shall coordinate with the Office of Health Strategy to identify opportunities for the integration of certified community health workers into the medical assistance program. Not later than January 1, 2024, and annually thereafter until the reimbursement program is fully implemented, the Department of Social Services shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to human services and the Council on Medical Assistance Program Oversight. Such report shall contain an update on the certified community health worker reimbursement program and an evaluation of its impact on health outcomes and health equity.

Sec. 12. Subsection (b) of section 19a-754a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The Office of Health Strategy shall be responsible for the following:

(1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;

(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

(3) Directing and overseeing the State Innovation Model Initiative and related successor initiatives;

(4) (A) Coordinating the state's health information technology initiatives, (B) seeking funding for and overseeing the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 19a-775a, (C) establishing and maintaining a consumer health information Internet web site under section 19a-755b, and (D) designating an unclassified individual from the office to perform the duties of a health information technology officer as set forth in sections 17b-59f and 17b-59g;

(5) Directing and overseeing the Health Systems Planning Unit established under section 19a-612 and all of its duties and responsibilities as set forth in chapter 368z;

(6) Convening forums and meetings with state government and external stakeholders, including, but not limited to, the Connecticut Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies;

(7) Consulting with the Commissioner of Social Services, Insurance Commissioner and Connecticut Health Insurance Exchange on the Covered Connecticut program described in section 19a-754c; **[**and**]**

(8) (A) Setting an annual health care cost growth benchmark and primary care spending target pursuant to section 19a-754g, (B) developing and adopting health care quality benchmarks pursuant to section 19a-754g, (C) developing strategies, in consultation with stakeholders, to meet such benchmarks and targets developed pursuant to section 19a-754g, (D) enhancing the transparency of provider entities, as defined in subdivision (13) of section 19a-754f, (E) monitoring the development of accountable care organizations and patient-centered medical homes in the state, and (F) monitoring the adoption of alternative payment methodologies in the state; and

(9) Convening forums and meetings with Access Health Connecticut, the Department of Public Health, the birth-to-three program, as defined in section 17a-248, state home visiting programs, community action

agencies, hospitals, community health centers and other state government and external stakeholders to align community health worker programs funded by the state medical assistance program, block grants, health care providers, private insurance carriers and other external stakeholders.

Sec. 13. Section 17b-312 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services shall seek, in accordance with the provisions of section 17b-8 and in consultation with the Insurance Commissioner and the Office of Health Strategy established under section 19a-754a, as amended by this act, a waiver under Section 1115 of the Social Security Act, as amended from time to time, to **[**seek**]** obtain federal funds to support the Covered Connecticut program established under section 19a-754c. Upon approval by the Centers for Medicare and Medicaid Services, the Commissioner of Social Services shall implement the waiver.

(b) Not later than thirty days after the effective date of this section, the commissioner shall amend the waiver submitted in accordance with subsection (a) of this section, to the extent permissible under federal law and in accordance with section 17b-8, to provide coverage through the Covered Connecticut program to persons otherwise qualified for the program whose income does not exceed two hundred per cent of the federal poverty level. The commissioner shall consult with the Insurance Commissioner and the executive director of the Office of Health Strategy in submitting the waiver amendment.

Sec. 14. (NEW) (*Effective from passage*) (a) Not later than sixty days after the effective date of this section, the Commissioner of Social Services, in consultation with the Insurance Commissioner and the executive director of the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act, shall develop a plan for a second tier of the Covered Connecticut program established pursuant to section 19a-754c of the general statutes. The plan shall provide state-assisted health care coverage for persons otherwise

qualified for the program whose income exceeds two hundred per cent of the federal poverty level but does not exceed three hundred per cent of the federal poverty level.

(b) The plan developed pursuant to subsection (a) of this section may include (1) reduced benefits from the Covered Connecticut program, provided such benefits are in accordance with the requirements of 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 thereunder, and (2) income-based copayments by enrollees.

(c) The Commissioner of Social Services shall submit the plan developed in accordance with this section to 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. Not later than thirty days after the date of their receipt of such plan, the joint standing committees shall hold a public hearing on the plan. At the conclusion of a public hearing held in accordance with the provisions of this section, the joint standing committees shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's plan. If the joint standing committees advise the commissioner of their denial of approval, the commissioner shall not implement the plan. If such committees do not concur, the committee chairpersons shall appoint a committee of conference which shall be composed of three members from each joint standing committee. At least one member appointed from each joint standing committee shall be a member of the minority party. The report of the committee of conference shall be made to each joint standing committee, which shall vote to accept or reject the report. The report of the committee of conference may not be amended. If a joint standing committee rejects the report of the committee of conference, that joint standing committee shall notify the commissioner of the rejection and the commissioner's plan shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies

shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's plan. If the joint standing committees do not so advise the commissioner during the thirty-day period, the plan shall be deemed denied. Any implementation of the plan developed pursuant to this section shall be in accordance with the approval or modifications, if any, of 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.

(d) To the extent permissible under federal law, the commissioner may seek approval of a Medicaid waiver in accordance with section 17b-8 of the general statutes to obtain federal financial participation for the plan developed pursuant to this section.

Sec. 15. Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The exchange shall:

(1) Administer the exchange for both qualified individuals and qualified employers;

(2) Commission surveys of individuals, small employers and health care providers on issues related to health care and health care coverage;

(3) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the Affordable Care Act, and section 38a-1086, of health benefit plans as qualified health plans;

(4) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(5) Provide for enrollment periods, as provided under Section 1311(c)(6) of the Affordable Care Act;

(6) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized

comparative information on such plans including, but not limited to, the enrollee satisfaction survey information under Section 1311(c)(4) of the Affordable Care Act and any other information or tools to assist enrollees and prospective enrollees evaluate qualified health plans offered through the exchange;

(7) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs of the exchange, including information on moneys lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

(8) On or before the open enrollment period for plan year 2017, assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the Affordable Care Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

(9) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Service Act, 42 USC 300gg-15, as amended from time to time;

(10) Inform individuals, in accordance with Section 1413 of the Affordable Care Act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, as amended from time to time, or any applicable state or local public program, and enroll an individual in such program if the exchange determines, through screening of the application by the exchange, that such individual is eligible for any such program;

(11) Collaborate with the Department of Social Services, to the extent possible, to allow an enrollee who loses premium tax credit eligibility under Section 36B of the Internal Revenue Code and is eligible for HUSKY A or any other state or local public program, to remain enrolled

in a qualified health plan;

(12) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the Affordable Care Act;

(13) Establish a program for small employers through which qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

(14) Offer enrollees and small employers the option of having the exchange collect and administer premiums, including through allocation of premiums among the various insurers and qualified health plans chosen by individual employers;

(15) Grant a certification, subject to Section 1411 of the Affordable Care Act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

(A) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(16) Provide to the Secretary of the Treasury of the United States the following:

(A) A list of the individuals granted a certification under subdivision (15) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual

who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code because:

(i) The employer did not provide minimum essential health benefits coverage; or

(ii) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under Section 1411(b)(4) of the Affordable Care Act that such individual has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(17) Provide to each employer the name of each employee, as described in subparagraph (B) of subdivision (16) of this section, of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform duties required of, or delegated to, the exchange by the Secretary or the Secretary of the Treasury of the United States related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

(19) Select entities qualified to serve as Navigators in accordance with Section 1311(i) of the Affordable Care Act and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans;

(B) Distribute fair and impartial information concerning enrollment

in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing reductions under Section 1402 of the Affordable Care Act;

(C) Facilitate enrollment in qualified health plans;

(D) Provide referrals to the Office of the Healthcare Advocate or health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(20) Review the rate of premium growth within and outside the exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(21) Credit the amount, in accordance with Section 10108 of the Affordable Care Act, of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer;

(22) Consult with stakeholders relevant to carrying out the activities required under sections 38a-1080 to 38a-1090, inclusive, including, but not limited to:

(A) Individuals who are knowledgeable about the health care system, have background or experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment

in qualified health plans;

(C) Representatives of small employers and self-employed individuals;

(D) The Department of Social Services; and

(E) Advocates for enrolling hard-to-reach populations;

(23) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the Insurance Commissioner and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Affordable Care Act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) Not use any funds in carrying out its activities under sections 38a-1080 to 38a-1089, inclusive, that are intended for the administrative and operational expenses of the exchange, for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications;

(24) (A) Seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange, (B) encourage health carriers to offer tiered health care provider network plans that have different cost-sharing rates for different health care provider tiers and reward enrollees for choosing

low-cost, high-quality health care providers by offering lower copayments, deductibles or other out-of-pocket expenses, and (C) offer any such tiered health care provider network plans through the exchange;

(25) Report at least annually to the General Assembly on the effect of adverse selection on the operations of the exchange and make legislative recommendations, if necessary, to reduce the negative impact from any such adverse selection on the sustainability of the exchange, including recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Affordable Care Act, self-insured plans, plans sold through the exchange and plans sold outside the exchange; **[**and**]**

(26) Consult with the Commissioner of Social Services, Insurance Commissioner and Office of Health Strategy, established under section 19a-754a, as amended by this act, for the purposes set forth in section 19a-754c; and

(27) (A) Notwithstanding the provisions of section 12-15, the exchange shall make a written request to the Commissioner of Revenue Services, for return or return information, as such terms are defined in section 12-15, for use in conducting targeted outreach to uninsured residents of this state. If the Commissioner of Revenue Services deems such return or return information to be relevant to the targeted outreach to uninsured residents, said commissioner may disclose such information to the exchange. To effectuate the disclosure of such information, the Commissioner of Revenue Services and the exchange shall enter into a memorandum of understanding that sets forth the specific information to be disclosed and contains the terms and conditions under which said commissioner will disclose such information to the exchange. Any return or return information disclosed by the Commissioner of Revenue Services shall not be redisclosed by

the recipient to a third party without permission from the commissioner and shall only be used by the exchange in the manner prescribed in the memorandum of understanding. Any person who violates the provisions of this subparagraph shall be fined not more than five thousand dollars.

(B) To assist the exchange in conducting targeted outreach to uninsured residents of this state, the Commissioner of Revenue Services shall revise the tax return form prescribed under chapter 229 to include space on the tax return for residents to authorize the exchange to contact such residents regarding enrollment through the exchange. The Commissioner of Revenue Services and the exchange shall develop language to be included on the tax return form and shall include in the instructions accompanying the tax return a description of how the authorization provided will be relayed to the exchange.

Sec. 16. Section 19a-42 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(a) To protect the integrity and accuracy of vital records, a certificate registered under chapter 93 may be amended only in accordance with sections 19a-41 to 19a-45, inclusive, chapter 93, regulations adopted by the Commissioner of Public Health pursuant to chapter 54 and uniform procedures prescribed by the commissioner. Only the commissioner may amend birth certificates to reflect changes concerning parentage or the legal name of a parent or birth or marriage certificates to reflect changes concerning gender. **[**change.**]** Amendments related to parentage, **[**or**]** gender change or the legally changed name of a parent shall result in the creation of a replacement certificate that supersedes the original, and shall in no way reveal the original language changed by the amendment. Any amendment to a vital record made by the registrar of vital statistics of the town in which the vital event occurred or by the commissioner shall be in accordance with such regulations and uniform procedures.

(b) The commissioner and the registrar of vital statistics shall maintain sufficient documentation, as prescribed by the commissioner,

to support amendments and shall ensure the confidentiality of such documentation as required by law. The date of amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made part of the record and the original certificate shall be marked "Amended", except for amendments [due to] concerning parentage, [or] gender change or the legally changed name of a parent. When the registrar of the town in which the vital event occurred amends a certificate, such registrar shall, within ten days of making such amendment, forward an amended certificate to the commissioner and to any registrar having a copy of the certificate. When the commissioner amends a birth certificate, including changes [due to] concerning parentage, [or] gender change or the legally changed name of a parent, the commissioner shall forward an amended certificate to the registrars of vital statistics affected and their records shall be amended accordingly.

(c) An amended certificate shall supersede the original certificate that has been changed and shall be marked "Amended", except for amendments [due to] concerning parentage, [or] gender change or the legally changed name of a parent. The original certificate in the case of amendments concerning parentage, [or] gender change or the legally changed name of a parent shall be physically or electronically sealed and kept in a confidential file by the department and the registrar of any town in which the birth was recorded, and may be unsealed for issuance only as provided in section 7-53 with regard to an original birth certificate or upon a written order of a court of competent jurisdiction. The amended certificate shall become the official record.

(d) (1) Upon receipt of (A) an acknowledgment of parentage executed in accordance with the provisions of sections 46b-476 to 46b-487, inclusive, by both parents of a child, or (B) a certified copy of an order of a court of competent jurisdiction establishing the parentage of a child, the commissioner shall include on or amend, as appropriate, such child's birth certificate to show such parentage if parentage is not already shown on such birth certificate and to change the name of the child under eighteen years of age if so indicated on the acknowledgment

of parentage form or within the certified court order as part of the parentage action. If a person who is the subject of a voluntary acknowledgment of parentage, as described in this subdivision, is eighteen years of age or older, the commissioner shall obtain a notarized affidavit from such person affirming that such person agrees to the commissioner's amendment of such person's birth certificate as such amendment relates to the acknowledgment of parentage. The commissioner shall amend the birth certificate for an adult child to change the child's name only pursuant to a court order.

(2) If the birth certificate lists the information of a parent other than the parent who gave birth, the commissioner shall not remove or replace the parent's information unless presented with a certified court order that meets the requirements specified in section 7-50, or upon the proper filing of a rescission, in accordance with the provisions of section 46b-570. The commissioner shall thereafter amend such child's birth certificate to remove or change the name of the parent other than the person who gave birth and, if relevant, to change the name of the child, as requested at the time of the filing of a rescission, in accordance with the provisions of section 46b-570. Birth certificates amended under this subsection shall not be marked "Amended".

(e) When the parent or parents of a child request the amendment of the child's birth certificate to reflect a new name of the parent who gave birth because the name on the original certificate is fictitious, such parent or parents shall obtain an order of a court of competent jurisdiction declaring the person who gave birth to be the child's parent. Upon receipt of a certified copy of such order, the department shall amend the child's birth certificate to reflect the parent's true name.

(f) Upon receipt of a certified copy of an order of a court of competent jurisdiction changing the name of a person born in this state and upon request of such person or such person's parents, guardian, or legal representative, the commissioner or the registrar of vital statistics of the town in which the vital event occurred shall amend the birth certificate to show the new name by a method prescribed by the department.

(g) When an applicant submits the documentation required by the regulations to amend a vital record, the commissioner shall hold a hearing, in accordance with chapter 54, if the commissioner has reasonable cause to doubt the validity or adequacy of such documentation.

(h) When an amendment under this section involves the changing of existing language on a death certificate due to an error pertaining to the cause of death, the death certificate shall be amended in such a manner that the original language is still visible. A copy of the death certificate shall be made. The original death certificate shall be sealed and kept in a confidential file at the department and only the commissioner may order it unsealed. The copy shall be amended in such a manner that the language to be changed is no longer visible. The copy shall be a public document.

(i) The commissioner shall issue a new birth certificate to reflect a gender change upon receipt of the following documents submitted in the form and manner prescribed by the commissioner: (1) A written request from the applicant, signed under penalty of law, for a replacement birth certificate to reflect that the applicant's gender differs from the sex designated on the original birth certificate; (2) a notarized affidavit by a physician licensed pursuant to chapter 370 or holding a current license in good standing in another state, a physician assistant licensed pursuant to chapter 370 or holding a current license in good standing in another state, an advanced practice registered nurse licensed pursuant to chapter 378 or holding a current license in good standing in another state, or a psychologist licensed pursuant to chapter 383 or holding a current license in good standing in another state, stating that the applicant has undergone surgical, hormonal or other treatment clinically appropriate for the applicant for the purpose of gender transition; and (3) if an applicant is also requesting a change of name listed on the original birth certificate, proof of a legal name change. The new birth certificate shall reflect the new gender identity by way of a change in the sex designation on the original birth certificate and, if applicable, the legal name change.

(j) The commissioner shall issue a new birth certificate to reflect the legally changed name of a parent of the child who is the subject of such birth certificate upon receipt of the following documents, submitted in a form and manner prescribed by the commissioner: (1) A written request from the parent, signed under penalty of law, for a replacement birth certificate to reflect that the parent's legal name differs from the name designated on the original birth certificate, and (2) proof of such parent's legal name change.

[(j)**]** (k) The commissioner shall issue a new marriage certificate to reflect a gender change upon receipt of the following documents, submitted in a form and manner prescribed by the commissioner: (1) A written request from the applicant, signed under penalty of law, for a replacement marriage certificate to reflect that the applicant's gender differs from the sex designated on the original marriage certificate, along with an affirmation that the marriage is still legally intact; (2) a notarized statement from the spouse named on the marriage certificate to be amended, consenting to the amendment; (3) (A) a United States passport or amended birth certificate or court order reflecting the applicant's gender as of the date of the request, or (B) a notarized affidavit by a physician licensed pursuant to chapter 370 or holding a current license in good standing in another state, physician assistant licensed pursuant to chapter 370 or holding a current license in good standing in another state, an advanced practice registered nurse licensed pursuant to chapter 378 or holding a current license in good standing in another state or a psychologist licensed pursuant to chapter 383 or holding a current license in good standing in another state stating that the applicant has undergone surgical, hormonal or other treatment clinically appropriate for the applicant for the purpose of gender transition; and (4) if an applicant is also requesting a change of name listed on the original marriage certificate, proof of a legal name change. The new marriage certificate shall reflect the new gender identity by way of a change in the sex designation on the original marriage certificate and, if applicable, the legal name change.

Sec. 17. (NEW) (*Effective from passage*) (a) For purposes of this section,

"inmate" and "prisoner" have the same meanings as provided in section 18-84 of the general statutes.

(b) Not later than thirty days after the written request of any inmate or prisoner whose name has been ordered changed pursuant to section 45a-99 or section 52-11 of the general statutes, the Commissioner of Correction shall change such inmate or prisoner's name in the records of the Department of Correction in accordance with such order. Any such written request shall be accompanied by a certified copy of such order.

Sec. 18. Section 18-81ii of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

Any inmate of a correctional institution, as described in section 18-78, who has a gender identity that differs from the inmate's assigned sex at birth and has a diagnosis of gender dysphoria, as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" or gender incongruence, as defined in the 11th revision of the "International Statistical Classification of Diseases and Related Health Problems", shall: (1) Be addressed by correctional staff in a manner that is consistent with the inmate's gender identity, (2) have access to commissary items, clothing, personal property, programming and educational materials that are consistent with the inmate's gender identity, and (3) have the right to be searched by a correctional staff member of the same gender identity, unless the inmate requests otherwise or under exigent circumstances. An inmate who has a birth certificate, passport or driver's license that reflects his or her gender identity or who can meet established standards for obtaining such a document to confirm the inmate's gender identity shall presumptively be placed in a correctional institution with inmates of the gender consistent with the inmate's gender identity. Such presumptive placement may be overcome by a demonstration by the Commissioner of Correction, or the commissioner's designee, that the placement would present significant safety, management or security problems. In making determinations pursuant to this section, the inmate's views with respect

to his or her safety shall be given serious consideration by the Commissioner of Correction, or the commissioner's designee.

Sec. 19. Section 52-571m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(a) As used in this section:

(1) "Reproductive health care services" includes all medical, surgical, counseling or referral services relating to the human reproductive system, including, but not limited to, services relating to pregnancy, contraception or the termination of a pregnancy and all medical care relating to treatment of gender dysphoria as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" and gender incongruence, as defined in the 11th revision of the "International Statistical Classification of Diseases and Related Health Problems"; and

(2) "Person" includes an individual, a partnership, an association, a limited liability company or a corporation.

(b) When any person has had a judgment entered against such person, in any state, where liability, in whole or in part, is based on the alleged provision, receipt, assistance in receipt or provision, material support for, or any theory of vicarious, joint, several or conspiracy liability derived therefrom, for reproductive health care services that are permitted under the laws of this state, such person may recover damages from any party that brought the action leading to that judgment or has sought to enforce that judgment. Recoverable damages shall include: (1) Just damages created by the action that led to that judgment, including, but not limited to, money damages in the amount of the judgment in that other state and costs, expenses and reasonable attorney's fees spent in defending the action that resulted in the entry of a judgment in another state; and (2) costs, expenses and reasonable attorney's fees incurred in bringing an action under this section as may be allowed by the court.

(c) The provisions of this section shall not apply to a judgment entered in another state that is based on: (1) An action founded in tort, contract or statute, and for which a similar claim would exist under the laws of this state, brought by the patient who received the reproductive health care services upon which the original lawsuit was based or the patient's authorized legal representative, for damages suffered by the patient or damages derived from an individual's loss of consortium of the patient; (2) an action founded in contract, and for which a similar claim would exist under the laws of this state, brought or sought to be enforced by a party with a contractual relationship with the person that is the subject of the judgment entered in another state; or (3) an action where no part of the acts that formed the basis for liability occurred in this state.

Sec. 20. Section 52-571n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(a) As used in this section:

(1) "Gender-affirming health care services" means all medical care relating to the treatment of gender dysphoria as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" and gender incongruence, as defined in the 11th revision of the "International Statistical Classification of Diseases and Related Health Problems";

(2) "Reproductive health care services" includes all medical, surgical, counseling or referral services relating to the human reproductive system, including, but not limited to, services relating to pregnancy, contraception or the termination of a pregnancy; and

(3) "Person" includes an individual, a partnership, an association, a limited liability company or a corporation.

(b) When any person has had a judgment entered against such person, in any state, where liability, in whole or in part, is based on the alleged provision, receipt, assistance in receipt or provision, material

support for, or any theory of vicarious, joint, several or conspiracy liability derived therefrom, for reproductive health care services and gender-affirming health care services that are permitted under the laws of this state, such person may recover damages from any party that brought the action leading to that judgment or has sought to enforce that judgment. Recoverable damages shall include: (1) Just damages created by the action that led to that judgment, including, but not limited to, money damages in the amount of the judgment in that other state and costs, expenses and reasonable attorney's fees spent in defending the action that resulted in the entry of a judgment in another state; and (2) costs, expenses and reasonable attorney's fees incurred in bringing an action under this section as may be allowed by the court.

(c) The provisions of this section shall not apply to a judgment entered in another state that is based on: (1) An action founded in tort, contract or statute, and for which a similar claim would exist under the laws of this state, brought by the patient who received the reproductive health care services or gender-affirming health care services upon which the original lawsuit was based or the patient's authorized legal representative, for damages suffered by the patient or damages derived from an individual's loss of consortium of the patient; (2) an action founded in contract, and for which a similar claim would exist under the laws of this state, brought or sought to be enforced by a party with a contractual relationship with the person that is the subject of the judgment entered in another state; or (3) an action where no part of the acts that formed the basis for liability occurred in this state.

Sec. 21. Subsection (b) of section 45a-106a of the general statutes, as amended by section 52 of public act 22-26, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(b) The fee to file each of the following motions, petitions or applications in a Probate Court is two hundred fifty dollars:

(1) With respect to a minor child: (A) Appoint a temporary guardian, temporary custodian, guardian, coguardian, permanent guardian or statutory parent, (B) remove a guardian, including the appointment of

another guardian, (C) reinstate a parent as guardian, (D) terminate parental rights, including the appointment of a guardian or statutory parent, (E) grant visitation, (F) make findings regarding special immigrant juvenile status, (G) approve placement of a child for adoption outside this state, (H) approve an adoption, (I) validate a foreign adoption, (J) review, modify or enforce a cooperative postadoption agreement, (K) review an order concerning contact between an adopted child and his or her siblings, (L) resolve a dispute concerning a standby guardian, (M) approve a plan for voluntary services provided by the Department of Children and Families, (N) determine whether the termination of voluntary services provided by the Department of Children and Families is in accordance with applicable regulations, (O) conduct an in-court review to modify an order, (P) grant emancipation, (Q) grant approval to marry, (R) transfer funds to a custodian under sections 45a-557 to 45a-560b, inclusive, (S) appoint a successor custodian under section 45a-559c, (T) resolve a dispute concerning custodianship under sections 45a-557 to 45a-560b, inclusive, and (U) grant authority to purchase real estate;

(2) Determine parentage;

(3) Validate a genetic surrogacy agreement;

(4) Determine the age and date of birth of an adopted person born outside the United States;

(5) With respect to adoption records: (A) Appoint a guardian ad litem for a biological relative who cannot be located or appears to be incompetent, (B) appeal the refusal of an agency to release information, (C) release medical information when required for treatment, and (D) grant access to an original birth certificate;

(6) Approve an adult adoption;

(7) With respect to a conservatorship: (A) Appoint a temporary conservator, conservator or special limited conservator, (B) change residence, terminate a tenancy or lease, sell or dispose household

furnishings, or place in a long-term care facility, (C) determine competency to vote, (D) approve a support allowance for a spouse, (E) grant authority to elect the spousal share, (F) grant authority to purchase real estate, (G) give instructions regarding administration of a joint asset or liability, (H) distribute gifts, (I) grant authority to consent to involuntary medication, (J) determine whether informed consent has been given for voluntary admission to a hospital for psychiatric disabilities, (K) determine life-sustaining medical treatment, (L) transfer to or from another state, (M) modify the conservatorship in connection with a periodic review, (N) excuse accounts under rules of procedure approved by the Supreme Court under section 45a-78, (O) terminate the conservatorship, and (P) grant a writ of habeas corpus;

(8) With respect to a power of attorney: (A) Compel an account by an agent, (B) review the conduct of an agent, (C) construe the power of attorney, and (D) mandate acceptance of the power of attorney;

(9) Resolve a dispute concerning advance directives or life-sustaining medical treatment when the individual does not have a conservator or guardian;

(10) With respect to an elderly person, as defined in section 17b-450: (A) Enjoin an individual from interfering with the provision of protective services to such elderly person, and (B) authorize the Commissioner of Social Services to enter the premises of such elderly person to determine whether such elderly person needs protective services;

(11) With respect to an adult with intellectual disability: (A) Appoint a temporary limited guardian, guardian or standby guardian, (B) grant visitation, (C) determine competency to vote, (D) modify the guardianship in connection with a periodic review, (E) determine life-sustaining medical treatment, (F) approve an involuntary placement, (G) review an involuntary placement, (H) authorize a guardian to manage the finances of such adult, and (I) grant a writ of habeas corpus;

(12) With respect to psychiatric disability: (A) Commit an individual

for treatment, (B) issue a warrant for examination of an individual at a general hospital, (C) determine whether there is probable cause to continue an involuntary confinement, (D) review an involuntary confinement for possible release, (E) authorize shock therapy, (F) authorize medication for treatment of psychiatric disability, (G) review the status of an individual under the age of sixteen as a voluntary patient, and (H) recommit an individual under the age of sixteen for further treatment;

(13) With respect to drug or alcohol dependency: (A) Commit an individual for treatment, (B) recommit an individual for further treatment, and (C) terminate an involuntary confinement;

(14) With respect to tuberculosis: (A) Commit an individual for treatment, (B) issue a warrant to enforce an examination order, and (C) terminate an involuntary confinement;

(15) Compel an account by the trustee of an inter vivos trust, custodian under sections 45a-557 to 45a-560b, inclusive, or treasurer of an ecclesiastical society or cemetery association;

(16) With respect to a testamentary or inter vivos trust: (A) Construe, validate, divide, combine, reform, modify or terminate the trust, (B) enforce the provisions of a pet trust, (C) excuse a final account under rules of procedure approved by the Supreme Court under section 45a-78, and (D) assume jurisdiction of an out-of-state trust;

(17) Authorize a fiduciary to establish a trust;

(18) Appoint a trustee for a missing person;

[(19) Change a person's name;**]**

[(20)**]** (19) Issue an order to amend the birth certificate of an individual born in another state to reflect a gender change;

[(21)**]** (20) Require the Department of Public Health to issue a delayed birth certificate;

[(22)**]** (21) Compel the board of a cemetery association to disclose the minutes of the annual meeting;

[(23)**]** (22) Issue an order to protect a grave marker;

[(24)**]** (23) Restore rights to purchase, possess and transport firearms;

[(25)**]** (24) Issue an order permitting sterilization of an individual;

[(26)**]** (25) Approve the transfer of structured settlement payment rights; and

[(27)**]** (26) With respect to any case in a Probate Court other than a decedent's estate: (A) Compel or approve an action by the fiduciary, (B) give instruction to the fiduciary, (C) authorize a fiduciary to compromise a claim, (D) list, sell or mortgage real property, (E) determine title to property, (F) resolve a dispute between cofiduciaries or among fiduciaries, (G) remove a fiduciary, (H) appoint a successor fiduciary or fill a vacancy in the office of fiduciary, (I) approve fiduciary or attorney's fees, (J) apply the doctrine of cy pres or approximation, (K) reconsider, modify or revoke an order, and (L) decide an action on a probate bond.

Sec. 22. (*Effective from passage*) (a) As used in this section, "gender-affirming procedure" means a medical procedure or treatment to alter the physical characteristics of a person diagnosed with (1) gender dysphoria, as described in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", or (2) gender incongruence, as defined in the 11th revision of the "International Statistical Classification of Diseases and Related Health Problems", in a manner consistent with such person's gender identity.

(b) The Commissioner of Social Services shall establish a working group to seek input on amendments to the department's gender-affirming procedures guidelines not later than one hundred twenty days before amending such guidelines. The working group shall consist of (1) six health care providers who treat persons seeking gender-

affirming procedures or persons who have had such procedures, (2) two HUSKY Health program members who have had such procedures, and (3) the commissioner or the commissioner's designee. All appointments to the working group shall be made by the commissioner. The commissioner, or the commissioner's designee, shall serve as cochairperson of the working group with a member chosen by the majority of working group members to serve as cochairperson.

(c) The commissioner, or the commissioner's designee, shall convene the working group not later than ninety days before any amendments planned for the gender-affirming procedures guidelines. The group shall meet not less than two times monthly.

(d) The commissioner shall file a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health not later than thirty days before any amendments the commissioner has proposed for the gender-affirming procedure guidelines. The report shall include, but not be limited to, (1) the proposed amendments, and (2) the working group's recommendations concerning such amendments. The working group shall terminate on the date such report is issued.

(e) The provisions of this section shall not apply to any changes required to be made to the gender-affirming procedure guidelines to comply with federal law or regulations concerning reimbursement for such procedures under Title XIX or Title XXI of the Social Security Act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2023*	19a-754b(d)
Sec. 2	*January 1, 2024, and applicable to contracts entered into, amended or renewed on and after January 1, 2024*	New section

Sec. 3	*January 1, 2024, and applicable to contracts entered into, amended or renewed on and after January 1, 2024*	New section
Sec. 4	*January 1, 2024, and applicable to contracts entered into, amended or renewed on and after January 1, 2024*	New section
Sec. 5	*July 1, 2023*	New section
Sec. 6	*July 1, 2023*	New section
Sec. 7	*July 1, 2023*	New section
Sec. 8	*July 1, 2023*	3-112
Sec. 9	*January 1, 2024*	38a-477g
Sec. 10	*July 1, 2023*	17b-242(a)
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	19a-754a(b)
Sec. 13	*from passage*	17b-312
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	38a-1084
Sec. 16	*July 1, 2023*	19a-42
Sec. 17	*from passage*	New section
Sec. 18	*July 1, 2023*	18-81ii
Sec. 19	*July 1, 2023*	52-571m
Sec. 20	*July 1, 2023*	52-571n
Sec. 21	*July 1, 2023*	45a-106a(b)
Sec. 22	*from passage*	New section

Statement of Legislative Commissioners:

In Section 1(d)(3), "wholesale acquisition cost of the drug" was changed to "wholesale acquisition cost of the drug, less all rebates paid to the state for such drug during the immediately preceding calendar year," for consistency; Section 6 was redrafted for clarity; in Section 7(c), "thirty days after the effective date of this section" was changed to "August 1, 2023" for clarity; in Section 7(d), "sixty days after the effective date of this section" was changed to "September 1, 2023" for clarity; in Section 9(b)(1), "**[**2017**]** 2024" was changed to "2017" for clarity; in Sections 9(f) and 9(g) "On and after January, 1 2024," was added for clarity; in Section 16(c), "in the case of parentage" was changed to "in the case of amendments concerning parentage" for accuracy; in Sections 18 to 20, inclusive, "11th edition of the "International Statistical Classification of

Diseases and Related Health Problems"" was changed to "11th revision of the "International Statistical Classification of Diseases and Related Health Problems"" for accuracy; and in Section 22, "(NEW)" was removed for accuracy, "11th edition of the "International Statistical Classification of Diseases and Related Health Problems"" was changed to "11th revision of the "International Statistical Classification of Diseases and Related Health Problems"" for accuracy, and the first sentence of Section 22(b) was redrafted for clarity.

HS	*Joint Favorable C/R*	APP
APP	*Joint Favorable Subst.-LCO*	

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

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 24 $	FY 25 $	FY 26 $
State Comptroller - Fringe Benefits	GF - Potential Savings	None	None	See Below
Attorney General	GF - Revenue Gain	None	None	See Below
Social Services, Dept.	GF - Cost	See Below	See Below	See Below
Department of Revenue Services	GF - Cost	Up to 75,000	None	None
Public Health, Dept.	GF - Cost	30,000	None	None
Judicial Dept.	PCAF - Revenue Loss	600,000	600,000	600,000

Note: GF=General Fund; PCAF=Probate Court Administration Fund

Municipal Impact:

Municipalities	Effect	FY 24 $	FY 25 $	FY 26 $
Various Municipalities	Savings	None	None	See Below

Explanation

Sections 2-4 may result in savings to the state and retiree health plans, as well as fully insured municipal plans through prescription drug price limitations established in the bill. Any savings to the plans will be used to reduce prescription drug costs to the insureds. Savings will begin in 2026 and accumulating in the outyears as the U.S. Health and Human Services (HHS) secretary negotiates the maximum fair price for prescription drugs.

Section 4 also provides the Office of the Attorney General (OAG) with exclusive authority to enforce violations of the provisions contained within Sections 3 and 4 of the bill, which could result in a General Fund revenue gain beginning in FY 26 to the extent enforcement results in fines issued. The bill requires that manufacturers or distributors would be subject to a civil penalty of (1) $500,000, or (2) the purchaser's amount of annual savings generated from the maximum fair price limits in Section 3.

Section 10 mandates at least two licensed clinical social worker visits for each individual enrolled in home and community-based services waivers administered by the Department of Social Services. This results in significant costs to DSS and would be based on the number of clients receiving services, the rate paid, and the extent to which individuals are receiving services regardless of need.

Section 11 results in a cost to the Department of Social Services associated with designing and implementing a program to provide Medicaid reimbursement to certified community health workers. The extent of cost to the state depends on the Medicaid rate to be established and the utilization of services provided by community health workers.

Section 13 results in a cost to the Department of Social Services of $16.5 million in FY 24 and $43.3 million in FY 25 to increase the income limit for the CoveredCT program to 200% of the Federal Poverty Level.

Section 14 results in additional program costs to the Department of Social Services to the extent the plan to expand income eligibility up to 300% FPL is approved and implemented.

Section 15, which requires personal income tax forms and instructions to be revised for certain specified purposes, results in a one-time cost of up to $75,000 to the Department of Revenue Services in FY 24 associated with programming updates to the CTax tax administration system and myconneCT online portal, as well as form modification.

Section 15 may also result in minimal costs to the exchange (i.e.,

Access Health CT), to its own resources as a quasi-public agency, associated with using tax return data for targeted outreach and marketing. The exchange already conducts marketing using its own funds. Any additional costs resulting from the MOU would be incurred only after a revised tax return form is in use.

Section 16, which requires the Department of Public Health (DPH) and municipal registrars of vital statistics to issue an amended birth certificate to reflect a parent's legally changed name upon the receipt of certain documents, is anticipated to result in an Information Technology consultant cost of approximately $30,000 in FY 24 only to update DPH's Electronic Birth Registry to allow for these names changes. There is no fee associated with the issuance of amended birth certificates and, therefore, no anticipated revenue gain to the state or municipalities.

Section 21 removes the $250 filing fee that the Probate Court collects for name change petitions resulting in an estimated $600,000 annual loss in revenue to the Probate Court Administration Fund (PCAF).

The bill also makes technical, clarifying, and procedural changes that result in no fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future: 1) subject to prescription drug prices negotiated by the U.S. Health and Human Services (HHS) secretary; 2) based upon the number of name change petitions; 3) to the extent to which enforcement by OAG results in the recoupment of fines; and 4) subject to inflationary measures.

OLR Bill Analysis

sSB 10

AN ACT PROMOTING ACCESS TO AFFORDABLE PRESCRIPTION DRUGS, HEALTH CARE COVERAGE, TRANSPARENCY IN HEALTH CARE COSTS, HOME AND COMMUNITY-BASED SUPPORT FOR VULNERABLE PERSONS AND RIGHTS REGARDING GENDER IDENTITY AND EXPRESSION.

TABLE OF CONTENTS:

§ 8 — PRESCRIPTION DRUG DISCOUNT CARD PROGRAM

Requires the comptroller to establish and administers a prescription drug discount card program available to all state residents

§ 9 — PROHIBITED CONTRACT CLAUSES IN HEALTH CARE

Prohibits health insurance carriers, health care providers, and certain others from entering into health care contracts that include all-or-nothing clauses, anti-steering clauses, anti-tiering clauses, or any other clause that results or intends to result in anticompetitive effects

§ 10 — SOCIAL WORKERS AND HOME CARE

Requires DSS to include at least two licensed clinical social worker visits in the fee schedule for people enrolled in CHCPE or any DSS-administered home- and community-based waiver

§§ 11 & 12 — COMMUNITY HEALTH WORKERS

Requires DSS to provide Medicaid reimbursement to certified community health workers and requires OHS to convene forums and meetings with stakeholders to align community health worker programs funded through various sources

§§ 13 & 14 — COVERED CONNECTICUT EXPANSION

Requires DSS to (1) amend the Covered Connecticut waiver to expand eligibility to households with incomes up to 200% of FPL and (2) submit a plan to certain legislative committees on further expanding eligibility to households with incomes up to 300% of FPL

§ 15 — TAX RETURN INFORMATION FOR ACCESS HEALTH OUTREACH

Requires Access Health CT and DRS to share tax return information so that Access Health CT may do targeted outreach to uninsured state residents

§ 16 — VITAL RECORDS BIRTH CERTIFICATES

Allows people who submit certain documentation to change birth certificates to reflect changes to a parent's legal name

§ 17 — INMATE NAME CHANGE

Requires DOC, within 30 days of receiving an inmate's or prisoner's written request, to change the person's name in department records

§ 18 — INMATES WITH GENDER INCONGRUENCE

Provides inmates with a diagnosis of gender incongruence with certain rights, such as (1) having DOC staff address them based on their gender identity and (2) with exceptions, being placed in a correctional institution consistent with their gender identity

§§ 19 & 20 — REPRODUCTIVE AND GENDER-AFFIRMING HEALTH CARE SERVICES AND GENDER INCONGRUENCE

Expands reproductive and gender-affirming health care services to include gender incongruence for the purposes of a cause of action for recovery for persons against whom a judgment was entered in another state for their participation in providing or receiving these services that are legal in Connecticut; specifies gender dysphoria treatment is set based on the most recent American Psychiatric Association manual

§ 21 — NAME CHANGE FEE ELIMINATION

Eliminates the $250 probate court filing fee to change a person's name

§ 22 — DSS GENDER AFFIRMING PROCEDURES WORKGROUP

Requires DSS to establish a working group to seek input on department guidelines for gender-affirming procedures at least 120 days before amending the guidelines

SUMMARY

This bill makes changes in laws affecting prescription drug pricing and reporting, clauses in health care contracts, provider rates for social workers and community health workers, Covered Connecticut eligibility, tax return information sharing, birth certificates and name changes, and gender identity provisions, as described in the section-by-section analysis below.

EFFECTIVE DATE: Various, see below

§ 1 — OHS OUTPATIENT PRESCRIPTION DRUG LIST

Allows a wider range of drugs to be included on OHS's annual list of 10 drugs that are provided at a substantial state cost, and gives manufacturers the opportunity, following a public comment period, to show that a drug does not meet the inclusion criteria

Existing law requires the Office of Health Strategy (OHS), in consultation with the comptroller and the commissioners of public health and social services, to annually identify up to 10 outpatient prescription drugs that are (1) provided at a substantial state cost, considering their net cost, or (2) critical to public health. Manufacturers of these identified drugs must give OHS certain information on the (1) factors that led to an increase in the drug's wholesale acquisition cost

and (2) company's research and development costs and other capital costs.

Current law sets certain parameters for the drugs OHS may include on this list, requiring both a minimum (1) percentage increase in the drug's cost over prior years and (2) total cost for a specified supply or course of treatment. As shown in the table below, the bill lowers the minimum required cost increase and total cost that qualifies a drug for inclusion on the list.

Table: Minimum Requirements for List of Outpatient Prescription Drugs

	Current Law	*Bill*
Cost increase	At least 20% during the prior year or 50% during the prior three years	At least 16% cumulatively during the two prior years
Cost for course of treatment	At least $60 for a 30-day supply or shorter course of treatment	At least $40 for a course of treatment of unspecified duration

The bill requires OHS to make the list public and to make a preliminary list available for public comment. Under the bill, the OHS executive director must prepare a preliminary list of outpatient prescription drugs she plans to include on the list. She must make the preliminary list available for public comment for at least 30 days. During the public comment period, any manufacturer of a drug included on the preliminary list may document that the drug's wholesale acquisition cost, less all rebates paid to the state during the last calendar year, does not exceed the criteria described above. The OHS executive director must remove the drug from the preliminary list if the manufacturer's documentation establishes, to the executive director's satisfaction, that the drug does not meet the criteria for inclusion. The OHS executive director must publish a final list within 15 days after the public comment period closes.

By law, OHS may impose a penalty of up to $7,500 on pharmaceutical manufacturers for violating these provisions.

EFFECTIVE DATE: July 1, 2023

Background — Related Bill

sHB 6669 (File 453), § 10, favorably reported by the Public Health Committee, contains nearly identical provisions, but is effective October 1, 2023.

§§ 2-4 — PURCHASER PRICE LIMIT ON PRESCRIPTION DRUGS

Prohibits purchasers (e.g., insurance plans) from purchasing prescription drugs for prices above the "maximum fair price" set by federal law for Medicare; requires purchasers to apply related savings towards reducing insureds' prescription drug costs; prohibits drug manufacturers and distributors from withdrawing drugs from sale or distribution in the state to avoid revenue loss; and sets penalties and reporting requirements

The bill prohibits certain purchasers (e.g., insurance plans, see below) from purchasing or seeking reimbursement for a prescription drug for a price above its maximum fair price (MFP) as established in federal law for certain drugs (i.e., a "referenced drug"). The bill applies only to drugs intended to be dispensed, delivered, or administered to an insured in the state, directly or through a distributor.

Maximum Fair Price

The federal Inflation Reduction Act (IRA) requires the U.S. Health and Human Services (HHS) secretary to negotiate the MFP for certain drugs covered under Medicare (generally based on those with the highest Medicare spending) and sets upper limits on the negotiated price. Under the IRA, the number of drugs subject to this negotiation increases over time (beginning with 10 drugs for the 2026 plan year) and certain drugs are exempted (e.g., those with generic versions). Generally, the MFP for a drug is applicable until a generic version is available (P.L. 117-169, § 1191). Under the bill, the MFP excludes any dispensing fee paid to a pharmacy to dispense a referenced drug.

Purchasers Subject to the Price Limit

A purchaser is any state entity, health benefit plan, or voluntarily participating Employee Retirement Income Security Act (ERISA) plan. Under the bill, a:

1. "state entity" is any state agency or anyone acting on the state's behalf that purchases a prescription drug for someone with

health insurance paid for by the state, including health insurance offered by local, state, or federal agencies or through organizations licensed in the state, but excluding Medicaid;

2. "health benefit plan" is an insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in the state by a health carrier to provide, deliver, pay for, or reimburse any health care services costs (see below for exempted coverage types and benefits); and

3. "participating ERISA plan" is any employee welfare benefit plan subject to the federal ERISA that elects to participate in the bill's price limit requirements.

The bill allows ERISA plans to elect to participate by notifying the Insurance Department in writing by January 1 each calendar year.

Purchasers Exempt From the Price Limit

The bill generally excludes single service ancillary health coverages (e.g., dental, vision, prescription drug), long-term care, workers' compensation, and any other coverages under which health care services are secondary or incidental to other insurance benefits, including those specified in certain federal HIPPA regulations. Exempted coverage types include:

1. disability income protection, accident only, long term care, specified accident, Medicare supplement, TriCare supplement, travel health, or single service ancillary health;

2. liability insurance (e.g., general or automotive) or coverage issued as a supplement to liability insurance; and

3. workers compensation, automobile medical payment insurance, credit insurance, and coverage for on-site medical clinics.

The bill also exempts benefits if they are provided under a separate insurance policy, certificate, or contract or are otherwise not an integral part of the plan (e.g., home health care benefits). It exempts hospital

confinement indemnity coverage, or specified disease coverage if (1) provided under a separate insurance policy, certificate, or contract, (2) there is no coordination between the provision of these benefits and the exclusion of benefits under a group health plan maintained by the same plan sponsor, and (3) the benefits are paid without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor.

Purchaser Savings and Reporting Requirement

The bill requires purchasers to calculate their savings that result from the price limit described above and apply these savings to reduce their insureds' prescription drugs costs. (The bill does not describe what higher price purchasers must use to calculate savings.)

The bill requires purchasers to report annually by January 15 to the Insurance Department to:

1. assess the purchaser's savings for each referenced drug for the previous year, and

2. identify how the purchaser applied savings to reduce prescription drug costs and decrease cost disparities.

Prohibiting Manufacturers and Distributors From Withdrawing Drugs From the Market

The bill prohibits certain manufacturers or distributors from withdrawing a referenced drug from sale or distribution in the state to attempt to avoid revenue loss resulting from the maximum fair price requirement described above. The bill requires manufacturers and distributors to provide at least 180 days' notice to the insurance commissioner and the attorney general before withdrawing a referenced drug from sale or distribution in the state.

Under the bill, manufacturers include (1) any entity (a) engaged in the production, preparation, propagation, compounding, conversion, processing, packaging, repackaging, labelling, relabeling or distributing prescription drug products and (b) subject to federal 340B price limits

(see *Background)* and (2) wholesalers distributing 340B covered drugs to these entities. A distributor is any entity, including a wholesaler, that supplies drugs, devices, or cosmetics prepared, produced, or packaged by manufacturers, to other wholesalers, manufacturers, distributors, hospitals, clinics, practitioners, or pharmacies or federal, state, and municipal agencies.

The bill prohibits referenced drug manufacturers and distributors from negotiating with a purchaser or seller of a referenced drug at a price that exceeds the MFP. (The bill does not define "seller.") The bill deems doing so a violation, but does not prescribe a penalty.

Regulations, Violations, and Penalties

The bill subjects purchasers that violate the bill's maximum fair price provisions to a $1,000 civil penalty for each violation.

For manufacturers and distributors that violate the bill's provisions on removing referenced drugs from the market, the bill sets a civil penalty of $500,000 or the purchaser's annual savings generated under the maximum fair price provisions, whichever is greater. (The amount of the second penalty is unclear as a distributor or wholesaler may work with multiple purchasers.)

The bill requires the insurance commissioner to adopt regulations to implement these provisions. It gives the attorney general exclusive authority to enforce its penalties.

EFFECTIVE DATE: January 1, 2024, and applicable to contracts entered into, amended, or renewed on and after that date.

Background — Federal 340 Price Limits

Under the 340B program, federal law requires the HHS secretary to enter into purchase agreement with drug manufacturers that participate in Medicaid. These agreements generally limit the price at which manufacturers may sell certain covered outpatient drugs to "covered entities" (e.g., federally qualified health centers, children's hospitals, and other providers that care for underserved populations) (42 U.S.C. §

256b).

§§ 5 & 6 — DRUG PRICING AND REPORTING FOR 340B ENTITIES

Prohibits 340B covered entities from trying to collect as medical debt any payment for a prescription drug obtained with a rebate or discounted price through the federal 340B drug pricing program if they charged the patient a higher price and establishes a prescription drug reporting requirement for these entities

Section 340B of the federal Public Health Service Act (i.e., the 340B Drug Pricing Program) requires drug manufacturers participating in Medicaid to sell certain outpatient prescription drugs ("covered drugs") at discounted prices to health care organizations that care for uninsured and low-income patients. These organizations include federally qualified health centers, children's hospitals, hospitals that serve a disproportionate number of low-income patients, and other safety net providers ("340B covered entities").

The bill prohibits these covered entities from trying to collect as medical debt a payment for a prescription drug prescribed by a health care provider to a person in the state that the entity gets with a rebate or discounted price through the 340B program that exceeds the entity's cost for the drug. Under the bill, a rebate is a discount or concession affecting an outpatient prescription drug price, that a pharmaceutical manufacturer directly provides to a (1) health carrier or (2) pharmacy benefits manager after the manager processes a claim from a pharmacist or pharmacy.

The bill also requires 340B covered entities to annually report by January 15 to the OHS executive director the following information on drugs prescribed by a health care provider to people in the state for the previous calendar year:

1. a list of all prescription drugs, identified by the national drug code number, purchased through the federal 340B drug pricing program;

2. the actual price of each prescription drug after any rebate or discount provided through the program;

3. the actual payment each 340B covered entity received from any private or public health insurance plan, excluding Medicaid and Medicare, or patient for each of these prescription drugs; and

4. the average percentage savings realized by each 340B covered entity on prescription drug costs under the program and how the entity used the savings.

The bill requires the executive director to link to the report on the OHS website.

EFFECTIVE DATE: July 1, 2023

Background — Related Bill

sHB 6669 (File 453), §§ 16-19, favorably reported by the Public Health Committee, makes various changes affecting 340B program participants, including (1) prohibiting pharmacy benefit managers (PBMs) from discriminating against 340B covered entities in connection with dispensing covered drugs, (2) requiring drug manufacturers to comply with specified federal pricing requirements when selling covered drugs to these entities, (3) allowing covered entities or the attorney general to seek relief if a PBM tries to enforce contract provisions that violate the bill, and (4) requiring hospitals that participate in the 340B program to annually report certain information to OHS.

§ 7 — PRESCRIPTION DRUG PAYMENT EVALUATION COMMITTEE

Establishes a Prescription Drug Payment Evaluation Committee to recommend to OHS upper payment limits on at least eight prescription drugs based on an evaluation of upper payment limits in other jurisdictions

The bill establishes a 23-member Prescription Drug Payment Evaluation Committee to recommend upper payment limits to the OHS executive director for at least eight prescription drugs based on an evaluation of upper payment limits set by other states or foreign jurisdictions.

Under the bill, the committee consists of the (1) Office of Policy and Management (OPM) secretary; OHS executive director; Healthcare

Advocate; Consumer Protection, Insurance, Public Health, and Social Services department commissioners; or their designees, and (2) appointed members shown in the table below.

Table: Appointed Members

Appointing Authority	*Members*
House speaker	• Statewide health care advocacy coalition representative • Statewide advocacy organization for elderly persons representative • Statewide organization for diverse communities representative
Senate president pro tempore	• Labor union representative • Health services researcher • Consumer who experienced cost barriers to obtaining prescription drugs
House majority leader	• 340 covered entity representatives (2)
House minority leader	• Private insurer representatives (2)
Senate majority leader	• Health care provider organization representatives (2)
Senate minority leader	• Representative of a pharmaceutical company doing business in the state • Representative of an academic institution with health care cost expertise
Governor	• Pharmacist representative • Pharmacy benefit manager representative

The bill requires appointing authorities to make initial appointments to the committee by August 1, 2023, and fill any vacancies. Under the bill, the House speaker and the Senate president pro tempore select the committee's chairpersons from among its members. The chairpersons must schedule the committee's first meeting, which must be held by September 1, 2023. The Insurance Committee administrative staff serves as the committee's administrative staff.

The bill requires the committee to report annually, beginning by

December 1, 2023, to the OHS executive director and the Appropriations, Human Services, Insurance, and Public Health committees on its recommendations for upper payment limits on at least eight prescription drugs.

EFFECTIVE DATE: July 1, 2023

§ 8 — PRESCRIPTION DRUG DISCOUNT CARD PROGRAM

Requires the comptroller to establish and administers a prescription drug discount card program available to all state residents

The bill requires the comptroller to establish and administer a prescription drug discount card program available to all state residents. It also authorizes the comptroller to coordinate participation in a multistate prescription drug consortium to pool purchasing power to lower costs by negotiating discounts with drug manufacturers and coordinating volume discount contracting.

EFFECTIVE DATE: July 1, 2023

Background — Related Bill

sHB 6669 (File 453), § 1, favorably reported by the Public Health Committee includes similar provisions.

§ 9 — PROHIBITED CONTRACT CLAUSES IN HEALTH CARE

Prohibits health insurance carriers, health care providers, and certain others from entering into health care contracts that include all-or-nothing clauses, anti-steering clauses, anti-tiering clauses, or any other clause that results or intends to result in anticompetitive effects

The bill prohibits health insurance carriers (generally, insurers and HMOs), health care providers, health plan administrators, or any agent or entity contracting on their behalf, beginning January 1, 2024, from offering, soliciting, requesting, amending, renewing, or entering a health care contract that directly or indirectly includes all-or-nothing clauses, anti-steering clauses, anti-tiering clauses, or any other clause that results or intends to result in anticompetitive effects. The bill explicitly does not prohibit "value-based care," which is a health care coverage model in which providers, including hospitals and physicians, are paid based on patient health outcomes.

Under the bill, any prohibited clause in a contract, written policy, written procedure, or agreement is null and void, but the contract's other clauses remain in effect for the contract term.

The bill allows the insurance commissioner to adopt regulations implementing these provisions.

Prohibited Clauses

Under the bill, an "all-or-nothing clause" requires health insurance carriers or health plan administrators to (a) include all members of a health care provider in a network plan or (b) contract with a provider's affiliate as a condition of contracting with the provider. Under the bill, a health plan administrator is a third-party administrator acting on a plan sponsor's behalf to administer a health benefit plan.

An "anti-steering clause" restricts a carrier or administrator from encouraging an enrollee to get health care services from a competing hospital or health system, including by offering incentives for enrollees to use specific health care providers.

An "anti-tiering clause" (1) restricts a health carrier's or plan administrator's ability to introduce or change a tiered network plan or assign health care providers into tiers or (2) requires a health carrier or plan administrator to place all members of a health care provider in the same tier. A "tiered network" identifies and groups some or all types of health care providers and facilities into specific groups to which different participating provider reimbursement, covered person cost-sharing, or participating provider access requirements apply for the same health care services.

EFFECTIVE DATE: January 1, 2024

Background — Related Bills

sSB 983 (File 341), favorably reported by the Insurance and Real Estate Committee, contains similar contract provisions.

sHB 6620 (File 326), favorably reported by the Insurance and Real

Estate and Judiciary committees, also contains similar provisions.

§ 10 — SOCIAL WORKERS AND HOME CARE

Requires DSS to include at least two licensed clinical social worker visits in the fee schedule for people enrolled in CHCPE or any DSS-administered home- and community-based waiver

The bill requires the Department of Social Services (DSS) commissioner to include in the fee schedule for home health services at least two licensed clinical social worker visits to each person enrolled in the Connecticut Home Care Program for Elders (CHCPE) or any home- and community-based Medicaid waiver program DSS administers.

CHCPE is a Medicaid waiver- and state-funded program that provides a range of home- and community-based services for eligible people ages 65 or older who are at risk of inappropriate institutionalization. DSS administers other home- and community-based waivers serving various populations (e.g., the Acquired Brain Injury waiver).

EFFECTIVE DATE: July 1, 2023

Background — Related Bills

sSB 412, favorably reported by the Appropriations and Human Services committees, requires DSS to increase rates for certain complex care nursing services in the fee schedule for home health services.

sSB 946, favorably reported by the Appropriations and Human Services committees, (1) requires DSS to compensate family caregivers who provide personal care services under CHCPE, (2) reduces cost sharing for the state-funded portion of the program, and (3) makes technical changes.

§§ 11 & 12 — COMMUNITY HEALTH WORKERS

Requires DSS to provide Medicaid reimbursement to certified community health workers and requires OHS to convene forums and meetings with stakeholders to align community health worker programs funded through various sources

The bill requires DSS to design and implement a program to give Medicaid reimbursement to certified community health workers (CHW)

for certain services provided to HUSKY Health (i.e., Medicaid and the state children's health insurance) members. Under existing law and the bill, a certified CHW is a public health outreach professional who:

1. has an in-depth understanding of a community's experience, language, culture, and socioeconomic needs;

2. provides services that include outreach, engagement, education, coaching, informal counseling, social support, advocacy, care coordination, and research, basic screenings, and risk assessments associated with social determinants of health (i.e., societal factors that contribute to a person's state of health); and

3. is certified by the Department of Public Health (DPH) as a CHW.

Under the bill, services CHWs may provide under DSS's program include:

1. coordination of medical, oral, and behavioral health care services and social supports;

2. connection to, and navigation of, health systems and services;

3. prenatal, birth, lactation, and postpartum supports; and

4. health promotion, coaching, and self-management education.

The bill requires the commissioner to reimburse certified CHW services in a way and at a rate conducive to workforce growth.

Throughout the program's design and implementation, the commissioner and her designees must consult with certified CHWs and others in a way that (1) includes community-based and clinic-based certified CHWs, (2) represents medical assistance program beneficiary demographics, and (3) helps shape the program's design and implementation. The bill also requires DSS to coordinate with OHS to identify opportunities to integrate CHWs into the medical assistance program.

The bill requires DSS, by January 1, 2024, and annually thereafter, until the program is fully implemented, to report to the Human Services Committee and the Council on Medical Assistance Program Oversight (MAPOC). The report must provide a program update and evaluate the program's impact on health outcomes and health equity.

The bill also requires OHS to convene forums and meetings with stakeholders to align CHW programs funded by state medical assistance program, block grants, private insurance carriers, and others. Stakeholders include Access Health Connecticut, DPH, the Birth-to-Three program, state home visiting programs, community action agencies, hospitals, community health centers, and other state government and external stakeholders. The bill sets this requirement as part of OHS's ongoing duties.

EFFECTIVE DATE: Upon passage

Background — Related Bill

sSB 991 (File 438), favorably reported by the Human Services Committee, similarly requires DSS to establish a program to reimburse certified CHWs and report to the Human Services Committee and MAPOC.

§§ 13 & 14 — COVERED CONNECTICUT EXPANSION

Requires DSS to (1) amend the Covered Connecticut waiver to expand eligibility to households with incomes up to 200% of FPL and (2) submit a plan to certain legislative committees on further expanding eligibility to households with incomes up to 300% of FPL

The bill expands eligibility for the Covered Connecticut health coverage program (see *Background*). It requires the DSS commissioner, within 30 days of its passage, to amend the state's Medicaid waiver supporting the program to expand eligibility to people otherwise qualified for the program with income up to 200% of the federal poverty level (FPL), rather than up to 175% of FPL, as under current law. She must do this to the extent federal law allows and according to existing law's legislative approval process for Medicaid waivers and waiver amendments (see *Background*). The bill also requires her to consult with

the insurance commissioner and the executive director of OHS in submitting this waiver amendment.

The bill further requires the DSS commissioner, within 60 days of its passage and in consultation with the insurance commissioner and OHS executive director, to develop a plan for a second tier of the Covered Connecticut program for people otherwise qualified for the program with income over 200% and up to 300% of FPL. Under the bill, the developed plan may offer (1) reduced benefits consistent with certain federal requirements and (2) income-based copayments by enrollees.

The DSS commissioner must submit this plan to the Appropriations, Human Services, and Insurance committees, which must then hold a public hearing within 30 days after receiving it. At the hearing's conclusion, the committees must advise the commissioner of their approval, denial, or modification of the plan.

If the committees disagree on the plan, the committee chairpersons must appoint a nine-member conference committee composed of three members from each committee. At least one member from each committee must be from the minority party. The conference committee must report to the standing committees, which must in turn vote to accept or reject, but not amend, the report. If a committee rejects the conference report, it must notify the commissioner, and the plan is deemed approved. If all the committees accept the report, the Appropriations Committee must advise the commissioner of the approval, denial, or modification of the plan.

If the committees advise the commissioner of their denial, she must not implement the plan. If they do not advise the commissioner within 30 days after receiving the plan, the plan is deemed denied. Any implementation of the plan must follow the committees' approval or modifications. The DSS commissioner may, to the extent permissible under federal law, seek approval of a Medicaid waiver to get federal funds for the developed plan.

EFFECTIVE DATE: Upon passage

Background — Covered Connecticut Program

This program provides no-cost health insurance, dental insurance, and non-emergency medical transportation to eligible adults and their tax dependents. Generally, program participants must (1) have household incomes too high to qualify for Medicaid but under program limits, (2) be covered by a silver-level health plan offered on the state's health insurance exchange (Access Health CT), and (3) qualify for federal qualified health plan premium and cost-sharing subsidies (CGS § 19a-754c).

Background — Legislative Approval Process

State law requires the DSS commissioner to submit federal waiver applications, renewals, and amendments to the Appropriations and Human Services committees before submitting them to the federal Centers for Medicare and Medicaid Services for approval. The committees must:

1. hold a public hearing within 30 days after receiving the application;

2. approve, deny, or modify a waiver application; and

3. appoint a conference committee if the committees do not agree on the decision (CGS § 17b-8).

For waivers on Covered Connecticut, the Insurance and Real Estate Committee also participates in this process (CGS § 19a-754c). (These requirements do not apply to applications for routine operational issues.)

Background — Related Bill

sSB 978, favorably reported by the Appropriations and Human Services committees, similarly requires the DSS commissioner to amend the Medicaid waiver to expand eligibility to 200% of FPL, but by January 1, 2024, rather than within 30 days after the bill's passage.

§ 15 — TAX RETURN INFORMATION FOR ACCESS HEALTH OUTREACH

Requires Access Health CT and DRS to share tax return information so that Access Health CT may do targeted outreach to uninsured state residents

The bill requires Access Health CT (i.e., the Connecticut Health Insurance Exchange) to make a written request to the Department of Revenue Services (DRS) commissioner for returns or return information to use for targeted outreach to uninsured state residents. By law, a "return" is any tax or information return, estimated tax declaration, or refund claims, among other things. "Return information" includes a taxpayer's identity; the nature, source, or amount of a taxpayer's income, payments, receipts, deductions, exceptions, credits, assets, liabilities, net worth; and any other data the DRS commissioner receives on a return (CGS § 12-15(h)).

Under the bill, if the DRS commissioner deems a return or return information relevant to the targeted outreach to uninsured residents, he may disclose it to the exchange. To make this disclosure, the bill requires the DRS commissioner and the exchange to enter into a memorandum of understanding (MOU) stating the specific information to be disclosed and the terms and conditions for disclosure. Under the bill, disclosed information may only be used by the exchange as described in the MOU. The bill prohibits anyone who receives disclosed information from DRS from redisclosing it to a third party without the commissioner's permission and sets a $5,000 fine for violating these provisions.

The bill further requires the DRS commissioner to revise the state's income tax return form to include a space for residents to authorize the exchange to contact them about health insurance enrollment through the exchange. It also requires the DRS commissioner and the exchange to write language for the tax return form (presumably related to the authorization space) and include, in the form's instructions, a description of how the authorization will be relayed to the exchange.

EFFECTIVE DATE: Upon passage

§ 16 — VITAL RECORDS BIRTH CERTIFICATES

Allows people who submit certain documentation to change birth certificates to reflect changes to a parent's legal name

The bill allows people who submit certain documentation to change birth certificates to reflect changes to a parent's legal name. The DPH commissioner must issue a new birth certificate in these instances when she receives (1) a written request from the parent, signed under penalty of law, for a replacement birth certificate with the parent's new legal name, and (2) proof of the parent's legal name change.

The bill generally extends to these amended birth certificates existing procedures for amended birth certificates reflecting gender change (e.g., allowing only the DPH commissioner, and not local registrars, to amend the certificate, and providing that the replacement certificate is not marked "amended").

EFFECTIVE DATE: July 1, 2023

§ 17 — INMATE NAME CHANGE

Requires DOC, within 30 days of receiving an inmate's or prisoner's written request, to change the person's name in department records

The bill requires the Department of Correction (DOC) commissioner to change an inmate or prisoner's name in department records within 30 days after he or she makes a written request. The inmate or prisoner must have had his or her name legally changed and provide the name change order.

By law, an "inmate" or "prisoner" includes anyone in DOC custody or confined in any DOC institution or facility until released from custody or control, including anyone on parole.

EFFECTIVE DATE: Upon passage

§ 18 — INMATES WITH GENDER INCONGRUENCE

Provides inmates with a diagnosis of gender incongruence with certain rights, such as (1) having DOC staff address them based on their gender identity and (2) with exceptions, being placed in a correctional institution consistent with their gender identity

By law, DOC must adhere to certain requirements on the treatment and placement of inmates with a diagnosis of gender dysphoria and a gender identity that differs from their assigned sex at birth. For example, (1) correctional staff must address the inmate according to their gender

identity and (2) except in limited circumstances, DOC must place an inmate with a documented gender identity change in an institution consistent with their gender identity.

The bill extends these requirements to include inmates with a gender incongruence diagnosis, which is characterized by a marked and persistent incongruence between someone's experienced gender and the assigned sex, provided that gender variant behavior and preferences alone are not a basis for diagnosis (11th revision of the "International Statistical Classification of Diseases and Related Health Problems").

EFFECTIVE DATE: July 1, 2023

§§ 19 & 20 — REPRODUCTIVE AND GENDER-AFFIRMING HEALTH CARE SERVICES AND GENDER INCONGRUENCE

Expands reproductive and gender-affirming health care services to include gender incongruence for the purposes of a cause of action for recovery for persons against whom a judgment was entered in another state for their participation in providing or receiving these services that are legal in Connecticut; specifies gender dysphoria treatment is set based on the most recent American Psychiatric Association manual

Existing law generally provides a cause of action for persons (i.e., an individual or certain legal entities) against whom a judgment was entered in another state based on their allegedly providing or receiving help from another person for reproductive or gender-affirming health care services that are legal in Connecticut. It allows the person to recover damages from any party that (1) brought the original action that resulted in the judgment or (2) tried to enforce it. The court must award a person who successfully brings an action the judgment amount entered in the other states and certain costs, expenses, and reasonable attorney's fees.

The bill expands the definition of "reproductive health care services" and "gender-affirming health care services," to include gender incongruence.

Under current law, these services also include all medical care relating to gender dysphoria treatment. The bill specifies that these treatments are set in the most recent edition of the American Psychiatric

Association's "Diagnostic and Statistical Manual of Mental Disorders."

EFFECTIVE DATE: July 1, 2023

§ 21 — NAME CHANGE FEE ELIMINATION

Eliminates the $250 probate court filing fee to change a person's name

The bill eliminates the $250 probate court filing fee for changing a person's name. By law, the superior and probate courts generally have concurrent jurisdiction to grant name changes (CGS § 45a-99). With exceptions, the Superior Court fee for a name change is $360, which remains unchanged by the bill (CGS § 52-259).

EFFECTIVE DATE: July 1, 2023

§ 22 — DSS GENDER AFFIRMING PROCEDURES WORKGROUP

Requires DSS to establish a working group to seek input on department guidelines for gender-affirming procedures at least 120 days before amending the guidelines

The bill requires the DSS commissioner to establish a working group to seek input on amendments to department guidelines for gender-affirming procedures. Under the bill, these procedures are (1) medical procedures or treatments to alter a person's physical characteristics to be consistent with the person's gender identity and (2) for people diagnosed with gender dysphoria (as described in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders") or gender incongruence (as defined in the "International Statistical Classification of Diseases and Related Health Problems," 11th revision).

The bill requires the DSS commissioner to make all appointments to the working group. The working group includes the following members:

1. six health care providers who treat people who seek or have had gender-affirming procedures;

2. two HUSKY Health program members who have had gender-affirming procedures; and

3. the DSS commissioner or her designee, who serves as co-chairperson with another member the majority of the workgroup chooses as the other co-chairperson.

The bill requires the DSS commissioner to establish the working group at least 120 days before amending the guidelines and convene it at least 90 days before any amendments planned for the guidelines. The working group must meet at least twice per month.

The bill requires the DSS commissioner to report to the Human Services and Public Health committees at least 30 days before any amendments the commissioner has proposed for the gender-affirming procedure guidelines. The report must include the proposed amendments and the working group's recommendations on them. The working group terminates when DSS issues the report. (Presumably, the bill's 120-, 90-, and 30-day deadlines are based on when changes to the guidelines take effect.)

The bill exempts from its requirements any changes DSS must make to comply with federal laws or regulations on Medicaid or the state Children's Health Insurance Program.

EFFECTIVE DATE: Upon passage

COMMITTEE ACTION

Human Services Committee

Joint Favorable Change of Reference - APP
Yea 14 Nay 7 (03/21/2023)

Appropriations Committee

Joint Favorable
Yea 36 Nay 14 (04/21/2023)