AN ACT CONCERNING THE GOVERNOR’S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES.

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

Section 1. Section 17b-265 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2020):

(a) In accordance with 42 USC 1396k, the Department of Social Services shall be subrogated to any right of recovery or indemnification that an applicant or recipient of medical assistance or any legally liable relative of such applicant or recipient has against an insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a
claim for a health care item or service, for the cost of all health care items
or services furnished to the applicant or recipient, including, but not
limited to, hospitalization, pharmaceutical services, physician services,
nursing services, behavioral health services, long-term care services and
other medical services, not to exceed the amount expended by the
department for such care and treatment of the applicant or recipient. In
the case of such a recipient who is an enrollee in a care management
organization under a Medicaid care management contract with the state
or a legally liable relative of such an enrollee, the department shall be
subrogated to any right of recovery or indemnification which the
enrollee or legally liable relative has against such a private insurer or
other third party for the medical costs incurred by the care management
organization on behalf of an enrollee.

(b) An applicant or recipient or legally liable relative, by the act of the
applicant's or recipient's receiving medical assistance, shall be deemed
to have made a subrogation assignment and an assignment of claim for
benefits to the department. The department shall inform an applicant of
such assignments at the time of application. Any entitlements from a
contractual agreement with an applicant or recipient, legally liable
relative or a state or federal program for such medical services, not to
exceed the amount expended by the department, shall be so assigned.
Such entitlements shall be directly reimbursable to the department by
third party payors. The Department of Social Services may assign its
right to subrogation or its entitlement to benefits to a designee or a
health care provider participating in the Medicaid program and
providing services to an applicant or recipient, in order to assist the
provider in obtaining payment for such services. In accordance with
subsection (b) of section 38a-472, a provider that has received an
assignment from the department shall notify the recipient's health
insurer or other legally liable third party including, but not limited to, a
self-insured plan, group health plan, as defined in Section 607(1) of the
Employee Retirement Income Security Act of 1974, service benefit plan,
managed care organization, health care center, pharmacy benefit
manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, of the assignment upon rendition of services to the applicant or recipient. Failure to so notify the health insurer or other legally liable third party shall render the provider ineligible for payment from the department. The provider shall notify the department of any request by the applicant or recipient or legally liable relative or representative of such applicant or recipient for billing information. This subsection shall not be construed to affect the right of an applicant or recipient to maintain an independent cause of action against such third party tortfeasor.

(c) Claims for recovery or indemnification submitted by the department, or the department's designee, shall not be denied solely on the basis of the date of the submission of the claim, the type or format of the claim, the lack of prior authorization or the failure to present proper documentation at the point-of-service that is the basis of the claim, if (1) the claim is submitted by the state within the three-year period beginning on the date on which the item or service was furnished; and (2) any action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of the claim.

(d) When a recipient of medical assistance has personal health insurance in force covering care or other benefits provided under such program, payment or part-payment of the premium for such insurance may be made when deemed appropriate by the Commissioner of Social Services. [Effective January 1, 1992, the] The commissioner shall limit reimbursement to medical assistance providers for coinsurance and deductible payments under Title XVIII of the Social Security Act to assure that the combined Medicare and Medicaid payment to the provider shall not exceed the maximum allowable under the Medicaid program fee schedules.

(e) No self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service
benefit plan, managed care plan, or any plan offered or administered by a health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, shall contain any provision that has the effect of denying or limiting enrollment benefits or excluding coverage because services are rendered to an insured or beneficiary who is eligible for or who received medical assistance under this chapter. No insurer, as defined in section 38a-497a, shall impose requirements on the state Medicaid agency, which has been assigned the rights of an individual eligible for Medicaid and covered for health benefits from an insurer, that differ from requirements applicable to an agent or assignee of another individual so covered.

(f) The Commissioner of Social Services shall not pay for any services provided under this chapter if the individual eligible for medical assistance has coverage for the services under an accident or health insurance policy.

(g) An insurer or other legally liable third party, upon receipt of a claim submitted by the department or the department's designee, in accordance with the requirements of subsection (c) of this section, for payment of a health care item or service covered under a state medical assistance program administered by the department, shall, not later than ninety days after receipt of the claim, or not later than ninety days after the effective date of this section, whichever is later, (1) make payment on the claim, (2) request information necessary to determine its legal obligation to pay the claim, or (3) issue a written reason for denial of the claim. Failure to pay, request information necessary to determine legal obligation to pay or issue a written reason for denial of a claim not later than one hundred twenty days after receipt of the claim, or not later than one hundred twenty days after the effective date of this section, whichever is later, creates an uncontestable obligation to pay the claim. The provisions of this subsection shall apply to all claims, including claims submitted by the department or the department's
designee, prior to July 1, 2020.

(h) On and after July 1, 2020, an insurer or other legally liable third party who has reimbursed the department for a health care item or service paid for and covered under a state medical assistance program administered by the department, shall, upon determining it is not liable and at risk for cost of the health care item or service, request any refund from the department not later than twelve months from the date of its reimbursement to the department.

Sec. 2. Section 315 of public act 19-117 is repealed. (Effective July 1, 2020)

This act shall take effect as follows and shall amend the following sections:

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<thead>
<tr>
<th>Section 1</th>
<th>July 1, 2020</th>
<th>17b-265</th>
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<tr>
<td>Sec. 2</td>
<td>July 1, 2020</td>
<td>Repealer section</td>
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Statement of Purpose:
To implement the Governor's budget recommendations.

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