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:

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

Appointing Authority	*Members*
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)