2025 Health Care Affordability State Policy Snapshot

CONNECTICUT

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HEALTHCARE VALUE HUB

State Has Active Legislation

State Does Not Have Active Legislation

The Health Care Value Hub ("the Hub") is proud to launch the 2025 Health Care Affordability Policy Snapshot ("Affordability Snapshot"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other interested parties a tool to compare their state's health policies across other states.

The categories examined in this resource explore a variety of policy options that impact health care affordability. Policies were examined for whether they were active, implemented to a limited degree, or not active as of June 1, 2025. Sources for this information can be found in the downloadable **Data and Source Document available on the Dashboard page. Definitions and descriptions for each policy category can be found in the Glossary.**

The Hub offers online and hands-on support with staff dedicated to understanding health care policy and connecting advocates and other interested parties together to help build a patient-centered, high-value healthcare system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Address Consolidation and Promote Competition

Consolidation Oversight

Policy	Status as of June 2025	Summary
Transaction Notification Required	Requires health systems or providers to notify the state of consolidation transactions	Connecticut law requires entities notify the Attorney General (and Office of Health Strategy in transactions involving nonprofit hospitals) of any material changes to group practices, hospitals, and other health care entities at least 30 days prior to the transaction. The state Certificate of Need program must also be notified of transfers of ownership of health care facilities.
Authority to Modify or Reject Consolidation Transactions	Has authority to approve, set conditions, or disapprove consolidation transactions	The Attorney General has authority to approve, apply conditions, or disapprove transactions for nonprofit hospitals, alongside the Executive Director of the Office of Health Strategy (OHS) in transactions involving nonprofit hospitals transfers of assets to for-profit hospitals. The Certificate of Need program also has authority to approve, set conditions, or disapprove transfers of ownership of certain health care providers.
Affordability Criteria included in Transaction Review	Includes consumer affordability or price growth in review criteria, approval conditions, or both	The Connecticut Certificate of Need program evaluates whether transactions involving a health care system or provider may negatively impact affordability. The Attorney General does not have authority to block or modify transactions beyond existing state antitrust law.

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

Address Consolidation and Promote Competition

Facility Fees

Policy	Status as of June 2025	Summary
Prohibits Facility Fees	State prohibits provider from charging a facility fee for specified procedures, care settings, or both	Connecticut prohibits facility fees for evaluation and management services and for telehealth services, with the exception of emergency departments and certain observation stays.
Facility Fee Transparency Laws	State requires providers to disclose facility fees to consumers and/or requires off-campus outpatient departments to identify the physical location where care was provided on claims forms	Connecticut requires that a hospital or health system that charges a facility fee must provide written notice to the patient that details the facility fee charge, an estimate of the charge, patient liability, and more. Connecticut also requires the reporting of facility fee data from hospital and health systems to the Office of Health Strategy annually.
Limits Cost-Sharing for Facility Fees	State has enacted legislation that prohibits balance billing for facility fees, requiring a separate copayment for facility fees, or both	Connecticut prohibits a separate copayment for off-campus outpatient facility fees.

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Address Consolidation and Promote Competition

Anti-Competitive Contract Provisions

Policy	Status as of June 2025	Summary
Restricts All-or-Nothing Contract Provisions	Law restricts All-or-Nothing contract provisions	Connecticut prohibits All-or-Nothing clauses in contracts between health organizations and health care providers.
Restricts Anti-Tiering and Anti-Steering Contract Provisions	Law restricts Anti-Tiering or Anti-Steering contract provisions	Connecticut prohibits including Anti-Tiering and Anti-Steering clauses in contracts between health organizations and health care providers.
Restricts Physician Noncompete Clauses	Non-competes for physicians limited by statute	Connecticut limits physician noncompete agreements to one year and within 15 miles of the physician's primary practice. They are unenforceable if the employer terminates the physician (unless for cause), fails to renew the agreement, or does not provide a material pay increase upon renewal.
Restricts Most-Favored Nation Contract Provisions	Law restricts Most Favored Nation contract provisions	Connecticut bans Most Favored Nation clauses in contracts between health organizations and providers, prohibiting guaranteed best rates, rate certification, or disclosure of other insurers' rates.

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Medical Debt Prevention

Balance Billing and Short-Term Insurance

Policy	Status as of June 2025	Summary
Prohibits Balance Billing for Ground Ambulance Services	⊗ Does not prohibit balance billing for out-of-network ground ambulance services	
Prohibits Short-Term, Limited Duration Health Plans	● State law has eliminated short-term, limited duration health plans	STLD health plans aren't explicitly banned in the state, but strict regulations have effectively removed them from the market.

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Medical Debt Prevention

Charity Care and Community Benefit

Policy	Status as of June 2025	Summary
Mandated Hospital Charity Care	State law requires hospitals to provide free or discounted care to low-income patients and sets standards for eligibility (see notes)	Connecticut law requires health care facilities that hold or administer hospital bed funds to offer financial assistance through these funds to eligible patients. However, the state has not established a uniform income threshold for eligibility.
Hospital Charity Care Screening Requirements	State does not require health care providers to screen patients for Medicaid, Marketplace, or charity care eligibility before collecting payment	
Hospital Charity Care Notification Requirement	State law requires health care providers to notify patients of charity care options before collecting payment	Hospitals in Connecticut are required to prominently post information (in English and Spanish) about hospital bed funds in key locations, provide printed summaries, and include them in all bills and collection notices.
Hospital Community Benefit Reporting Requirement	State law requires hospitals to annually report the amount of charity care provided	Connecticut hospitals must annually report to the state's Health Systems Planning Unit the number of applicants for charity care and reduced cost services, the number approved, and the total and average charges and costs of the care provided. They are also required to maintain detailed records of hospital bed fund activity and make this information available to the unit upon request.

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Medical Debt Prevention

Reducing Financial Consequences

Policy	Status as of June 2025	Summary
Mandates Waiting Prior to Collections	⊗ State law does not require a waiting period before sending medical debts to collections	Connecticut law does not specify a timeframe for selling medical debt, but hospitals may not refer a patient to collections unless the patient is uninsured and found ineligible for the hospital bed fund.
Limits on Liens or Foreclosures due to Medical Debt	● State law prohibits initiating a lien or foreclosure to collect medical debt	Connecticut law prohibits hospitals or creditors from foreclosing on a lien against a patient's primary residence for medical debt.
Limits Wage Garnishment due to Medical Debt	● State law exceeds federal wage garnishment protections for residents with medical debt	Connecticut bars hospitals and medical debt collectors from garnishing wages if a patient qualifies for subsidized care through the state hospital bed fund.
Limits on the Amount of Interest Charged to Medical Debt	● State law limits interest rates on medical debt	Connecticut law prohibits hospitals and their affiliates from charging interest or fees on medical debt owed by uninsured patients. For other patients, any interest on hospital-related debt is capped at 5% annually.

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Curb Excess Costs in the System

Premium Rate Review

Policy	Status as of June 2025	Summary
Effective Rate Review per Centers for Medicare and Medicaid Services (CMS)	Has an effective rate review process	
Authority to Modify or Reject Premium Rate Increases	Has the authority to modify or reject premium rate increases	Connecticut has the authority to approve or deny rate filings in in the individual, large group, and small group market.
Affordability Criteria Included in Premium Rate Review	Incorporates affordability criteria into premium rate review	Connecticut Senate Bill 10, passed in 2025, established rate filing requirements mandating that the Insurance Commissioner adopt regulations concerning affordability in rate filing and approval. Effective January 1, 2027, if the commissioner determines that a health carrier's average premium rate increase exceeds the health care cost growth benchmark for each of the two most recent plan years, the commissioner will have the authority to reduce the health carrier's requested rate filed.

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Curb Excess Costs in the System

Hospital Price Regulation

Policy	Status as of June 2025	Summary
Medicare Reference-Based Pricing	⊗ State does not use reference-based pricing tied to Medicare rates to regulate hospital pricing	
Hospital Global Budgets	● State has implemented hospital global budgets	In 2024, Connecticut was selected to participate in the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, a state total cost of care (TCOC) model.

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Curb Excess Costs in the System

Affordable Coverage

Policy	Status as of June 2025	Summary
Public Option	⊗ State does not offer an active public option insurance plan	
Public Option Includes Provider Participation Mandate	⊗ State does not does not offer a public option, with or without a participation mandate	
Basic Health Plan	⊗ State does not operate a Basic Health Plan	
State-Based Premium Subsidies	● Supplementary state-funded premium subsidies are available to eligible residents	Connecticut fully covers remaining premiums and cost-sharing for Silver plan enrollees with incomes up to 175% FPL after federal subsidies are applied. This program is expected to continue into 2026 regardless of federal action.

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Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Biologic Substitution Laws: Prescriber Permission Requirements	State does not require express authorization for biologic substitution	Pharmacists in Connecticut are authorized to substitute a biological product for a prescribed biological in most cases without express permission from the prescribing provider, unless the drug is used to treat epilepsy.
Biologic Substitution Laws: Prescriber Notification Requirements	Pharmacists are required to notify prescribers of biologic substitution	Most pharmacists in Connecticut are required to notify the prescribing physician of a substitution within forty-eight hours following the dispensing of an interchangeable biological product,
Drug Purchasing Consortium	State participates in a drug purchasing consortium (see note)	Connecticut is a member of ArrayRx (formerly the Northwest Prescription Drug Consortium) and the Top Dollar Program.
Drug Coupon Prohibitions	State does not prohibit the use of drug manufacturer coupons*	
Medicaid Managed Care Organization (MCO) Carve Out	State Medicaid does not carve out any drug classes from their MCO benefits*	
Mandatory Generics in Medicaid Fee-for-Service (FFS)	Medicaid Fee-for-Service (FFS) programs and pharmacists are required to substitute a generic version of a drug	Connecticut has policies or tools to promote mandatory generics.

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Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Supplemental Rebate Programs	Medicaid Pharmacy Supplemental Rebate Agreement (SRA) in place	
Drug Rebate Transparency and Reporting Requirements	Pharmacy benefit managers are required to report rebate data to the state	
Spread Pricing Restrictions	State does not prohibit pharmacy benefit managers from engaging in spread pricing	
Pharmacy Benefit Manager Reimbursement and Clawbacks	State does not prohibit PBMs from retroactively reducing reimbursement to pharmacies (“clawbacks”)	
Cost-Disclosure and Gag Clause Restrictions	State law prohibits gag clauses in pharmacy contracts	
Prohibits Copay Accumulator Programs	State prohibits copay accumulator programs	

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Curb Excess Costs in the System

Medicaid Costs

Policy	Status as of June 2025	Summary
Medical Loss Ratio Remittances (MLR) for Medicaid Managed Care Population	⊗ State does not require MLR remittances for its Medicaid managed care population	Connecticut uses some form of primary care case management but not MCOs.
Medicaid Site Neutral Payments	⊗ State has not enacted Medicaid site neutral payment legislation	Legislators in Connecticut introduced a bill in 2025 to establish site-neutral reimbursement for all covered health insurance benefits, but the bill was unsuccessful.

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Medicaid Services and Immigrant Coverage

Medicaid Administration

Policy	Status as of June 2025	Summary
Medicaid Managed Care (MCO)	⊗ State does not partner with MCOs to operate their Medicaid program	
Medicaid Vendor — Eligibility and Enrollment	● State contracts with a vendor for Medicaid enrollment or eligibility*	
Integrated Medicaid-Medicare	⊗ State does not integrate Medicare-Medicaid to coordinate care for the dually eligible population	

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Medicaid Services and Immigrant Coverage

Medicaid Covered Services

Policy	Status as of June 2025	Summary
Medicaid Coverage for Fertility Services	State Medicaid program does not cover infertility treatments or fertility preservation services	
Medicaid Coverage for Doula Services	The state has received approval to reimburse doula services under Medicaid but is still implementing the program	Connecticut's DSS program is incorporating doula care as part of its HUSKY Maternity Bundle Payment Program. This temporary measure ensures access to doula services until direct reimbursement procedures are fully developed.
Medicaid Coverage for Abortion Care	State Medicaid program utilizes state-based funds to cover abortion care	
Medicaid Coverage for Transition-Related Care	State Medicaid program explicitly covers any transition-related care for adults	
Medicaid Coverage for Hearing Aids	State Medicaid program covers hearing aids for all adults	
Medicaid Coverage for Eye Exams and Glasses	State Medicaid program covers only eye exams or eyeglasses but not both, or biannually or less frequently, or restricts coverage based on age or health condition (see notes)	Eyeglasses are covered biannually, eye exams are not subject to this limit.
Medicaid Coverage for Dental Services	State Medicaid program covers preventive and diagnostic dental services, extractions, dentures, root canals, fillings, and crowns for adults	

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Medicaid Services and Immigrant Coverage

Medicaid Eligibility

Policy	Status as of June 2025	Summary
Medicaid Expansion	State has expanded Medicaid eligibility to 138% of the federal poverty level (FPL)	
Retroactive Medicaid	State retroactively extends Medicaid benefits 90 days prior to application date for all adult enrollees	
Adult Medicaid Continuous Eligibility	State has not authorized 12-month continuous eligibility for non-pregnant adult Medicaid enrollees*	
12-Month Postpartum Coverage	State has authorized 12-month postpartum Medicaid coverage	
Medicaid Available to People who are Incarcerated	State has not authorized Medicaid coverage for justice-involved individuals while they are in a correctional setting*	Connecticut has a pending waiver to provide Medicaid pre-release coverage for individuals who are incarcerated.
Medicaid Aged, Blind and Disabled (ABD) Asset Limits	State has not expanded the asset limit for Medicaid for the Elderly and Disabled eligibility beyond $2,000 for an individual applicant and $3,000 for joint applicants	
Medicaid Aged, Blind and Disabled (ABD) Life Insurance Exemption	Life insurance exemption limits do not exceed $1,500	
Medicaid Aged, Blind and Disabled (ABD) Retirement Account Exemptions	State does not exempt retirement savings from Medicaid eligibility determinations	

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Medicaid Services and Immigrant Coverage

Immigrant Coverage

Policy	Status as of June 2025	Summary
From Conception to End of Pregnancy (FCEP)	Covers pregnancy-related services through the CHIP From-Conception-to-End-of-Pregnancy (FCEP) Option and post-partum coverage	Connecticut extends postpartum coverage to 12 months for parents covered by the From Conception to End of Pregnancy option.
Immigrant Children without a Five-Year Bar	State offers coverage for lawfully residing immigrant children without a five-year bar	
Pregnant Immigrants without a Five-Year Bar	Offers coverage for lawfully residing pregnant immigrants without a five-year bar	
State-Funded Coverage for Children Regardless of Citizenship Status	Offers coverage for children regardless of immigration status	
State-Funded Coverage for Adults Regardless of Citizenship Status	Does not offer coverage for adults regardless of immigration status	

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Improve Oversight, Accountability, and Transparency

All-Payer Claims Database

Policy	Status as of June 2025	Summary
Established an All-Payer Claims Database (APCD)	State has a(n) all-payer or multi-payer claims database	
All-Payer Claims Database (APCD) Operated by the State	APCD is operated by the state	

Prescription Drug Affordability Board

Policy	Status as of June 2025	Summary
Established Prescription Drug Affordability Board (PDAB)	The state has not established or passed legislation to establish a prescription drug affordability board	
Prescription Drug Upper Payment Limits	The state has not established Upper Payment Limits for prescription drugs	

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

Improve Oversight, Accountability, and Transparency

Price Transparency

Policy	Status as of June 2025	Summary
Service Cost Price Transparency Tool	⊗ State does not have a public-facing price transparency tool	
Prescription Drug Price Reporting Requirement	● Organizations are required to report prescription drug price information to a state entity	The executive director of the Office of Health Strategy (OHS) must annually report a list of ten outpatient drugs that have been provided at a significant cost to the state or are critical to public health. Manufacturers of drugs on the executive director's list must submit all of the factors that caused the increase in the wholesale acquisition cost of the drug to OHS.

Health Care Spending Oversight

Policy	Status as of June 2025	Summary
Health Care Spending Benchmark	● State has established a health care spending benchmark for providers, insurance carriers, or both	Connecticut's Cost Growth Benchmark was set at 3.4% for 2021 and set at 2.9% from 2023-2025. The benchmark applies to health insurance companies and healthcare providers with a minimum of 5,000 attributed lives. Notably, Connecticut's benchmarking uses the state's Healthcare Affordability Index to estimate the policy's impact on the number of Connecticut households that will have access to quality health care coverage and be able to meet their basic economic needs. The state also has a primary care spending target of 8.5% in 2024 increasing to 10% in 2025.
Authority to Enforce Health Care Spending Benchmark	⊗ State does not have an enforcement mechanism for their health care spending benchmark(s)	Connecticut's Office of Health Strategy has recommended, but not yet implemented, phasing in performance improvement plans ("PIP") for entities that exceed the benchmark and allowing civil penalty if they neglect to file a PIP, as well as incorporating the Benchmark into the review of annual insurer rate filings.
Hospital or Primary Care Spending Oversight Entity	● State monitors and reports hospital spending, primary care spending, or both	Connecticut's Healthcare Benchmark Initiative Steering Committee (HBISC) and the Office of Health Strategy, established in 2020, review hospital and primary care spending. This includes setting targets for primary care spending, set to reach 10% of total health care expenditures by 2025.

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Reduce Cost-Sharing for Patients

Reduce Cost-Sharing: Prescription Drugs

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Diabetes Medications	State has enacted legislation to limit cost-sharing for insulin, diabetes related equipment, or both	Connecticut caps the out-of-pocket cost for a 30-day supply of prescription insulin and covered diabetes-related equipment and supplies at $25.00 and $100.00, respectively.
Waives or Reduces Cost-Sharing for Asthma Inhalers	State has not enacted legislation limiting cost-sharing for asthma inhalers	
Waives or Reduces Cost-Sharing for Epinephrine Auto-Injectors	State has not enacted legislation to limit cost-sharing for prescription epinephrine autoinjector(s)	
Waives or Reduces Cost-Sharing for Specialty Drugs	State has not enacted legislation to limit cost-sharing for specialty drugs	

Reduced Cost-Sharing: Behavioral Health

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for an Annual Behavioral Health Office Visit	State requires private insurers to cover at least one annual mental health wellness exam without cost-sharing	Connecticut requires individual health insurance policies to provide coverage for two annual mental health wellness exams without patient cost-sharing.

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Preventive Care

Policy	Status as of June 2025	Summary
Waives Cost-Sharing for Preventive Services Recommended by the U.S. Preventive Services Task Force (USPSTF)	State mandates private insurers cover USPSTF recommended preventive services without cost-sharing	

Reduced Cost-Sharing: Maternal and Reproductive Health Care

Policy	Status as of June 2025	Summary
Individual and Small Group Health Plans Required to Cover Fertility Treatment	The state requires individual and small group health plans to offer coverage for in-vitro fertilization alone or in addition to fertility preservation services	Connecticut requires health insurance policies to cover standard fertility preservation and in-vitro fertilization (IVF).
Individual and Small Group Health Plans Required to Cover Doula Services	State does not require private health insurers to cover doula services for enrollees	
Individual and Small Group Health Plans Required to Cover Abortion Services	The state does not require individual and small group health plans to cover abortion services	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Colorectal Cancer Screenings	State law requires insurers to cover colorectal cancer screening but allows cost-sharing	Insurers in Connecticut are required to cover initial screening colonoscopy or screening sigmoidoscopy without imposing any restrictions related to deductibles.
Waives or Reduces Cost-Sharing for Follow-Up Colorectal Cancer Screening Exams	State law requires insurers to cover follow-up colorectal cancer screening tests with no cost-sharing	Insurers in Connecticut are required to cover additional colonoscopy following an initial screening colonoscopy or screening sigmoidoscopy without imposing any coinsurance, copayment, deductible, or other out-of-pocket expense.
Waives or Reduces Cost-Sharing for Lung Cancer Screenings	State law does not require coverage or waive cost-sharing for lung cancer screening exams	Connecticut law does not explicitly require insurance carriers to provide coverage for lung cancer screening, but the state does require carriers to cover USPSTF recommended services without cost-sharing, which includes health services rated "A" or "B" by the U.S. Preventive Services Task Force such as lung cancer screening.

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Cervical Cancer Screenings	State law requires insurers to cover cervical cancer screening tests with no cost-sharing	
Waives or Reduces Cost-Sharing for Breast Cancer Screenings	State law requires insurers to cover breast cancer screening with no cost-sharing	
Waives or Reduces Cost-Sharing for Supplementary Breast Cancer Screenings	State law requires insurers to cover supplementary breast cancer screening with no cost-sharing	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Prostate Cancer Screenings	State law requires insurers to cover prostate cancer screening but allows cost-sharing	
Waives or Reduces Cost-Sharing for Ovarian Cancer Screening	State law requires insurers to cover ovarian cancer screening with no cost-sharing	
Waives or Reduces Cost-Sharing for Biomarker Testing for Cancer	State does not require coverage or waive cost-sharing for biomarker testing	Connecticut will require all individual and group health insurance policies issued, renewed, or amended on or after January 1, 2026 to cover medically necessary biomarker testing.

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