# Senate

General Assembly

**File No. 420**

***January Session, 2025***

Substitute Senate Bill No. 11

*Senate, April 2, 2025*

The Committee on Human Services reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT CONCERNING PRESCRIPTION DRUG ACCESS AND AFFORDABILITY.***

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

Section 1. (NEW) (*Effective July 1, 2025*) For the purposes of this section and sections 2 and 3 of this act:

(1) "Biological product" has the same meaning as provided in section 20-619 of the general statutes;

(2) "Brand-name drug" means a drug that is produced or distributed in accordance with an original new drug application approved under 21 USC 355, as amended from time to time, but does not include an authorized generic drug as defined in 42 CFR 447.502, as amended from time to time;

(3) "Commissioner" means the Commissioner of Revenue Services;

(4) "Consumer price index" means the consumer price index, annual average, for all urban consumers: United States city average, all items,

published by the United States Department of Labor, Bureau of Labor Statistics, or its successor, or, if the index is discontinued, an equivalent index published by a federal authority, or, if no such index is published, a comparable index published by the United States Department of Labor, Bureau of Labor Statistics;

(5) "Generic drug" means (A) a prescription drug product that is marketed or distributed in accordance with an abbreviated new drug application approved under 21 USC 355, as amended from time to time, (B) an authorized generic drug as defined in 42 CFR 447.502, as amended from time to time, or (C) a drug that entered the market before calendar year 1962 that was not originally marketed under a new prescription drug product application;

(6) "Identified prescription drug" means (A) a brand-name drug or biological product for which the patent has expired for at least twenty-four months, or (B) a generic drug or interchangeable biological product;

(7) "Interchangeable biological product" has the same meaning as provided in section 20-619 of the general statutes;

(8) "Person" has the same meaning as provided in section 12-1 of the general statutes;

(9) "Pharmaceutical manufacturer" means a person that manufactures a prescription drug and sells, directly or through another person, the prescription drug for distribution in this state;

(10) "Prescription drug" means a legend drug, as defined in section 20-571 of the general statutes, approved by the federal Food and Drug Administration, or any successor agency, and prescribed by a health care provider to an individual in this state;

(11) "Reference price" means the wholesale acquisition cost, as defined in 42 USC 1395w-3a, as amended from time to time, of (A) a brand-name drug or biological product (i) on January 1, 2025, if the patent for the brand-name drug or biological product expired on or

before said date, or (ii) if the patent for the brand-name drug or biological product expires after January 1, 2025, on the date the patent for such brand-name drug or biological product expires, or (B) a generic drug or interchangeable biological product (i) on January 1, 2025, or (ii) if the generic drug or interchangeable biological product is first commercially marketed in the United States after January 1, 2025, on the date such generic drug or interchangeable biological product is first commercially marketed in the United States; and

(12) "Wholesale distributor" means a person, including, but not limited to, a repacker, own-label distributor, private-label distributor or independent wholesale drug trader, engaged in the wholesale distribution of prescription drugs.

Sec. 2. (NEW) (*Effective July 1, 2025*) (a) (1) Notwithstanding any provision of the general statutes and except as provided in subdivision (2) of this subsection, no pharmaceutical manufacturer or wholesale distributor shall, on or after January 1, 2026, sell an identified prescription drug in this state at a price that exceeds the reference price for the identified prescription drug, adjusted for any increase in the consumer price index.

(2) A pharmaceutical manufacturer or wholesale distributor may, on or after January 1, 2026, sell an identified prescription drug in this state at a price that exceeds the reference price for the identified prescription drug, adjusted for any increase in the consumer price index, if the federal Secretary of Health and Human Services determines, pursuant to 21 USC 356e, as amended from time to time, that such identified prescription drug is in shortage in the United States.

(b) (1) Except as provided in subdivision (2) of this subsection, any pharmaceutical manufacturer or wholesale distributor that violates the provisions of subsection (a) of this section shall be liable to this state for a civil penalty. Such civil penalty shall be imposed, calculated and collected on a calendar year basis by the Commissioner of Revenue Services, and the amount of such civil penalty for a calendar year shall be equal to eighty per cent of the difference between:

(A) The revenue that the pharmaceutical manufacturer or wholesale distributor earned from all sales of the identified prescription drug in this state during the calendar year; and

(B) The revenue that the pharmaceutical manufacturer or wholesale distributor would have earned from all sales of the identified prescription drug in this state during the calendar year if the pharmaceutical manufacturer or wholesale distributor had sold such identified prescription drug at a price that did not exceed the reference price for such identified prescription drug, as such reference price is adjusted for any increase in the consumer price index.

(2) No pharmaceutical manufacturer or wholesale distributor of an identified prescription drug shall be liable to this state for the civil penalty imposed under subdivision (1) of this subsection unless the pharmaceutical manufacturer or wholesale distributor made at least two hundred fifty thousand dollars in total annual sales in this state for the calendar year for which such civil penalty would otherwise be imposed.

(c) (1) (A) For calendar years commencing on or after January 1, 2026, each pharmaceutical manufacturer or wholesale distributor that violated the provisions of subsection (a) of this section during any calendar year shall, not later than the first day of March immediately following the end of such calendar year:

(i) Pay to the commissioner the civil penalty imposed under subsection (b) of this section for such calendar year; and

(ii) File with the commissioner a statement for such calendar year in a form and manner, and containing all information, prescribed by the commissioner.

(B) A pharmaceutical manufacturer or wholesale distributor that is required to file the statement and pay the civil penalty pursuant to subparagraph (A) of this subdivision shall electronically file such statement and make such payment by electronic funds transfer in the

manner provided by chapter 228g of the general statutes, irrespective of whether the pharmaceutical manufacturer or wholesale distributor would have otherwise been required to electronically file such statement or make such payment by electronic funds transfer under chapter 228g of the general statutes.

(2) If no statement is filed pursuant to subdivision (1) of this subsection, the commissioner may make such statement at any time thereafter, according to the best obtainable information and the prescribed form.

(d) The commissioner may examine the records of any pharmaceutical manufacturer or wholesale distributor that is subject to the civil penalty imposed under subsection (b) of this section as the commissioner deems necessary. If the commissioner determines from such examination that the pharmaceutical manufacturer or wholesale distributor failed to pay the full amount of such civil penalty, the commissioner shall bill such pharmaceutical manufacturer or wholesale distributor for the full amount of such civil penalty.

(e) (1) The commissioner may require each pharmaceutical manufacturer or wholesale distributor that is subject to the civil penalty imposed under subsection (b) of this section to keep such records as the commissioner may prescribe, and produce books, papers, documents and other data to provide or secure information pertinent to the enforcement and collection of such civil penalty.

(2) The commissioner, or the commissioner's authorized representative, may examine the books, papers, records and equipment of any person who is subject to the provisions of this section and may investigate the character of the business of such person to verify the accuracy of any statement made or, if no statement is made by such person, to ascertain and determine the amount of the civil penalty due under subsection (b) of this section.

(f) Any pharmaceutical manufacturer or wholesale distributor that is subject to the civil penalty imposed under subsection (b) of this section

and aggrieved by any action of the commissioner under subdivision (2) of subsection (c) of this section or subsection (d) of this section may apply to the commissioner, in writing and not later than sixty days after the notice of such action is delivered or mailed to such pharmaceutical manufacturer or wholesale distributor, for a hearing, setting forth the reasons why such hearing should be granted and if such pharmaceutical manufacturer or wholesale distributor believes that such pharmaceutical manufacturer or wholesale distributor is not liable for such civil penalty or the full amount of such civil penalty, the grounds for such belief and the amount by which such pharmaceutical manufacturer or wholesale distributor believes such civil penalty should be reduced. The commissioner shall promptly consider each such application and may grant or deny the hearing requested. If the hearing request is denied, the commissioner shall immediately notify the pharmaceutical manufacturer or wholesale distributor. If the hearing request is granted, the commissioner shall notify the pharmaceutical manufacturer or wholesale distributor of the date, time and place for such hearing. After such hearing, the commissioner may make such order as appears just and lawful to the commissioner and shall furnish a copy of such order to the pharmaceutical manufacturer or wholesale distributor. The commissioner may, by notice in writing, order a hearing on the commissioner's own initiative and require a pharmaceutical manufacturer or wholesale distributor, or any other person who the commissioner believes to be in possession of relevant information concerning such pharmaceutical manufacturer or wholesale distributor, to appear before the commissioner or the commissioner's authorized agent with any specified books of account, papers or other documents for examination under oath.

(g) Any pharmaceutical manufacturer or wholesale distributor that is aggrieved by any order, decision, determination or disallowance of the commissioner made under subsection (f) of this section may, not later than thirty days after service of notice of such order, decision, determination or disallowance, take an appeal therefrom to the superior court for the judicial district of New Britain, which appeal shall be accompanied by a citation to the commissioner to appear before said

court. Such citation shall be signed by the same authority and such appeal shall be returnable at the same time and served and returned in the same manner as is required in case of a summons in a civil action. The authority issuing the citation shall take from the appellant a bond or recognizance to this state, with surety, to prosecute the appeal to effect and to comply with the orders and decrees of the court. Such appeals shall be preferred cases, to be heard, unless cause appears to the contrary, at the first session, by the court or by a committee appointed by the court. Said court may grant such relief as may be equitable and, if the civil penalty was paid prior to the granting of such relief, may order the Treasurer to pay the amount of such relief. If the appeal was taken without probable cause, the court may tax double or triple costs, as the case demands and, upon all such appeals that are denied, costs may be taxed against such pharmaceutical manufacturer or wholesale distributor at the discretion of the court but no costs shall be taxed against this state.

(h) The commissioner, and any agent of the commissioner duly authorized to conduct any inquiry, investigation or hearing pursuant to this section, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the commissioner, the commissioner, or the commissioner's agent authorized to conduct such hearing and having authority by law to issue such process, may subpoena witnesses and require the production of books, papers and documents pertinent to such inquiry or investigation. No witness under any subpoena authorized to be issued under the provisions of this section shall be excused from testifying or from producing books, papers or documentary evidence on the ground that such testimony or the production of such books, papers or documentary evidence would tend to incriminate such witness, but such books, papers or documentary evidence so produced shall not be used in any criminal proceeding against such witness. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to such person by the commissioner, or the commissioner's authorized agent, or to produce any books, papers or other

documentary evidence pursuant thereto, the commissioner, or such agent, may apply to the superior court of the judicial district wherein the pharmaceutical manufacturer or wholesale distributor resides or wherein the business was conducted, or to any judge of such court if the same is not in session, setting forth such disobedience to process or refusal to answer, and such court or such judge shall cite such person to appear before such court or such judge to answer such question or to produce such books, papers or other documentary evidence and, upon such person's refusal to do so, shall commit such person to a community correctional center until such person testifies, but not for a period longer than sixty days. Notwithstanding the serving of the term of such commitment by any person, the commissioner may proceed in all respects with such inquiry and examination as if the witness had not previously been called upon to testify. Officers who serve subpoenas issued by the commissioner or under the commissioner's authority and witnesses attending hearings conducted by the commissioner pursuant to this section shall receive fees and compensation at the same rates as officers and witnesses in the courts of this state, to be paid on vouchers of the commissioner on order of the Comptroller from the proper appropriation for the administration of this section.

(i) The amount of any civil penalty unpaid under the provisions of this section may be collected under the provisions of section 12-35 of the general statutes. The warrant provided under section 12-35 of the general statutes shall be signed by the commissioner or the commissioner's authorized agent. The amount of any such civil penalty shall be a lien on the real property of the pharmaceutical manufacturer or wholesale distributor from the last day of the month next preceding the due date of such civil penalty until such civil penalty is paid. The commissioner may record such lien in the records of any town in which the real property of such pharmaceutical manufacturer or wholesale distributor is situated, but no such lien shall be enforceable against a bona fide purchaser or qualified encumbrancer of such real property. When any civil penalty with respect to which a lien was recorded under the provisions of this subsection is satisfied, the commissioner shall, upon request of any interested party, issue a certificate discharging such

lien, which certificate shall be recorded in the same office in which such lien was recorded. Any action for the foreclosure of such lien shall be brought by the Attorney General in the name of this state in the superior court for the judicial district in which the real property subject to such lien is situated, or, if such property is located in two or more judicial districts, in the superior court for any one such judicial district, and the court may limit the time for redemption or order the sale of such real property or make such other or further decree as the court judges equitable. The provisions of section 12-39g of the general statutes shall apply to all civil penalties imposed under this section.

(j) (1) Any officer or employee of a pharmaceutical manufacturer or wholesale distributor, who owes a duty to the pharmaceutical manufacturer or wholesale distributor to pay the civil penalty imposed under subsection (b) of this section on behalf of such pharmaceutical manufacturer or wholesale distributor, shall file a statement with the commissioner pursuant to subsection (c) of this section on behalf of such pharmaceutical manufacturer or wholesale distributor and keep records or supply information to the commissioner on behalf of such pharmaceutical manufacturer or wholesale distributor pursuant to this section. Any such officer or employee who wilfully fails, at the time required under this section, to pay such civil penalty, file such statement, keep such records or supply such information on behalf of such pharmaceutical manufacturer or wholesale distributor shall, in addition to any other penalty provided by law, be fined not more than one thousand dollars or imprisoned not more than one year, or both. Notwithstanding the provisions of section 54-193 of the general statutes, no such officer or employee shall be prosecuted for a violation of the provisions of this subdivision committed on or after January 1, 2026, except within three years next after such violation is committed.

(2) Any officer or employee of a pharmaceutical manufacturer or wholesale distributor, who owes a duty to the pharmaceutical manufacturer or wholesale distributor to deliver or disclose to the commissioner, or the commissioner's authorized agent, any list, statement, return, account statement or other document on behalf of

such pharmaceutical manufacturer or wholesale distributor, and who wilfully delivers or discloses to the commissioner, or the commissioner's authorized agent, any such list, statement, return, account statement or other document that such officer or employee knows to be fraudulent or false in any material matter shall, in addition to any other penalty provided by law, be guilty of a class D felony.

(3) No officer or employee of a pharmaceutical manufacturer or wholesale distributor shall be charged with an offense under both subdivisions (1) and (2) of this subsection in relation to the same civil penalty, but such officer or employee may be charged and prosecuted for both such offenses upon the same information.

(k) Each civil penalty imposed under subsection (b) of this section shall be deemed to constitute a civil fine or penalty within the meaning of 42 USC 1396b(w), as amended from time to time. No portion of any civil penalty imposed under subsection (b) of this section shall be waived under section 12-3a of the general statutes or any other applicable law. No tax credit shall be allowable against any civil penalty imposed under subsection (b) of this section.

(l) Not later than July 1, 2027, and annually thereafter, the commissioner shall prepare a list containing the name of each pharmaceutical manufacturer or wholesale distributor that violated subsection (a) of this section during the preceding calendar year. The commissioner shall make each such list publicly available.

(m) The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 3. (NEW) (*Effective July 1, 2025*) (a) No pharmaceutical manufacturer or wholesale distributor of an identified prescription drug shall withdraw the identified prescription drug from sale in this state for the purpose of avoiding the civil penalty established in subsection (b) of section 2 of this act.

(b) Any pharmaceutical manufacturer or wholesale distributor that intends to withdraw an identified prescription drug from sale in this state shall, at least one hundred eighty days before such withdrawal, send advance written notice to the Office of Health Strategy disclosing such pharmaceutical manufacturer's or wholesale distributor's intention.

(c) Any pharmaceutical manufacturer or wholesale distributor that violates the provisions of subsection (a) or (b) of this section shall be liable to this state for a civil penalty in the amount of five hundred thousand dollars.

Sec. 4. (NEW) (*Effective July 1, 2025*) (a) As used in this section and sections 5 and 6 of this act, "drug purchasing agency" means The University of Connecticut Health Center, the Judicial Branch and the Department of Mental Health and Addiction Services, Children and Families, Developmental Services or Public Health. The University of Connecticut Health Center shall negotiate bulk prices for prescription drugs on behalf of drug purchasing agencies with the goal of purchasing such drugs at lower prices than the prices of such drugs purchased by a single drug purchasing agency.

(b) Not later than September 1, 2025, the chief executive officer of The University of Connecticut Health Center, or the chief executive officer's designee, shall file a report, in accordance with the provisions of section 11-4a of the general statutes, with the joint standing committees of the General Assembly having cognizance of matters relating to general law, human services and public health on any savings realized from bulk purchases of prescription drugs pursuant to subsection (a) of this section.

Sec. 5. (NEW) (*Effective July 1, 2025*) (a) As used in this section, (1) "maximum fair prices" means the prices negotiated by the Centers for Medicare and Medicaid Services for certain prescription drugs under the Inflation Reduction Act, P.L. 117-69, and (2) "drug purchasing agency" has the same meaning as provided in section 4 of this act. A drug purchasing agency shall incorporate by reference maximum fair

prices in any negotiation with a pharmaceutical drug manufacturer to supply prescription drugs for health care programs subsidized by the state.

(b) In purchasing drugs at bulk prices pursuant to section 4 of this act or maximum fair prices pursuant to this section, a drug purchasing agency may enter into a compact with officials in other states to increase the state's purchasing power in negotiations with pharmaceutical companies. A drug purchasing agency shall consider recommendations of the council established pursuant to section 6 of this act in any negotiations for prescription drugs pursuant to this section or section 4 of this act.

Sec. 6. (NEW) (*Effective from passage*) (a) There is established a Prescription Drug Affordability Council to advise the chief executive officer of The University of Connecticut Health Center and drug purchasing agencies on prescription drug negotiations pursuant to sections 4 and 5 of this act. The council shall consist of the following members:

(b) (1) Two appointed by the speaker of the House of Representatives, one of whom represents an organization representing hospitals and one of whom represents an organization representing physicians;

(2) Two appointed by the president pro tempore of the Senate, one of whom represents an academic who has conducted research into the affordability of prescription drugs and one of whom represents an organization representing senior citizens in the state;

(3) One appointed by the majority leader of the House of Representatives, who represents physicians who treat patients with rare diseases;

(4) One appointed by the majority leader of the Senate;

(5) One appointed by the minority leader of the House of Representatives;

(6) One appointed by the minority leader of the Senate;

(7) The Commissioner of Health Strategy, or the commissioner's designee;

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

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

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

(11) The Commissioner of Children and Families, or the commissioner's designee.

(c) Any member of the council appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All initial appointments to the council shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the council from among the members of the council. Such chairpersons shall schedule the first meeting of the council, which shall be held not later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to human services shall serve as administrative staff of the council.

(g) Not later than January 1, 2026, and annually thereafter, the council shall submit a report on its findings and recommendations to the Commissioner of Health Strategy and the joint standing committees of the General Assembly having cognizance of matters relating to general

law, human services and public health, in accordance with the provisions of section 11-4a of the general statutes.

Sec. 7. Subsection (a) of section 17b-340d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

(a) The Commissioner of Social Services shall implement an acuity-based methodology for Medicaid reimbursement of nursing home services effective July 1, 2022. Notwithstanding section 17b-340, for the fiscal year ending June 30, 2023, and annually thereafter, the Commissioner of Social Services shall establish Medicaid rates paid to nursing home facilities based on cost years ending on September thirtieth in accordance with the following:

(1) Case-mix adjustments to the direct care component, which will be based on Minimum Data Set resident assessment data as well as cost data reported for the cost year ending September 30, 2019, shall be made effective beginning July 1, 2022, and updated every quarter thereafter. After modeling such case-mix adjustments, the Commissioner of Social Services shall evaluate impact on a facility by facility basis and, not later than October 1, 2021, (A) make recommendations to the Secretary of the Office of Policy and Management, and (B) submit a report on the recommendations, in accordance with the provisions of section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on any adjustments needed to facilitate the transition to the new methodology on July 1, 2022. This evaluation may include a review of inflationary allowances, case mix and budget adjustment factors and stop loss and stop gain corridors and the ability to make such adjustments within available appropriations.

(2) Beginning July 1, 2022, facilities **[**will be required to**]** shall comply with collection and reporting of quality metrics as specified by the Department of Social Services, after consultation with the nursing home industry, consumers, employees and the Department of Public Health. Rate adjustments based on performance on quality metrics **[**will**]** shall

be phased in, beginning July 1, 2022, with a period of reporting only. Effective July 1, 2023, the Department of Social Services shall issue individualized reports annually to each nursing home facility showing the impact to the Medicaid rate for such home based on the quality metrics program. A nursing home facility receiving an individualized quality metrics report may use such report to evaluate the impact of the quality metrics program on said facility's Medicaid reimbursement. Not later than June 30, 2025, the department shall submit a report, in accordance with the provisions of section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on the quality metrics program. Such report shall include information regarding individualized reports and the anticipated impact on nursing homes if the state were to implement a rate withhold on nursing homes that fail to meet certain quality metrics.

(3) Geographic peer groupings of facilities shall be established by the Department of Social Services pursuant to regulations adopted in accordance with subsection (b) of this section.

(4) Allowable costs shall be divided into the following five cost components: (A) Direct costs, which shall include salaries for nursing personnel, related fringe benefits and costs for nursing personnel supplied by a temporary nursing services agency; (B) indirect costs, which shall include professional fees, dietary expenses, housekeeping expenses, laundry expenses, supplies related to patient care, salaries for indirect care personnel and related fringe benefits; (C) fair rent, which shall be defined in regulations adopted in accordance with subsection (b) of this section; (D) capital-related costs, which shall include property taxes, insurance expenses, equipment leases and equipment depreciation; and (E) administrative and general costs, which shall include maintenance and operation of plant expenses, salaries for administrative and maintenance personnel and related fringe benefits. For (i) direct costs, the maximum cost shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; (ii) indirect costs, the maximum cost shall be equal to one hundred

fifteen per cent of the state-wide median allowable cost; (iii) fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 17b-353; (iv) capital-related costs, there shall be no maximum; and (v) administrative and general costs, the maximum shall be equal to the state-wide median allowable cost. For purposes of this subdivision, "temporary nursing services agency" and "nursing personnel" have the same meaning as provided in section 19a-118.

(5) Costs in excess of the maximum amounts established under this subsection shall not be recognized as allowable costs, except that the commissioner may establish rates whereby allowable costs may exceed such maximum amounts for beds which are restricted to use by patients with acquired immune deficiency syndrome, traumatic brain injury or other specialized services.

(6) On or after June 30, 2022, the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the most recently filed cost report that are not otherwise included in the rates issued. The commissioner may provide, within available appropriations, pro rata fair rent increases, which may, at the discretion of the commissioner, include increases for facilities which have undergone a material change in circumstances related to fair rent additions in the most recently filed cost report. The commissioner may allow minimum fair rent as the basis upon which reimbursement associated with improvements to real property is added.

(7) For the purpose of determining allowable fair rent, a facility with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Any facility with a rate of return on real property other than land in excess of eleven per cent shall have such allowance revised to eleven per cent. Any facility or its related realty affiliate which finances or refinances debt through bonds issued by the Connecticut Health and

Education Facilities Authority shall report the terms and conditions of such financing or refinancing to the Commissioner of Social Services not later than thirty days after completing such financing or refinancing. The commissioner may revise the facility's fair rent component of its rate to reflect any financial benefit the facility or its related realty affiliate received as a result of such financing or refinancing. The commissioner shall determine allowable fair rent for real property other than land based on the rate of return for the cost year in which such bonds were issued. The financial benefit resulting from a facility financing or refinancing debt through such bonds shall be shared between the state and the facility to an extent determined by the commissioner on a case-by-case basis and shall be reflected in an adjustment to the facility's allowable fair rent.

(8) A facility shall receive cost efficiency adjustments for indirect costs and for administrative and general costs if such costs are below the state-wide median costs. The cost efficiency adjustments shall equal twenty-five per cent of the difference between allowable reported costs and the applicable median allowable cost established pursuant to subdivision (4) of this subsection.

(9) On and after July 1, 2025, costs shall be rebased no more frequently than every two years and no less frequently than every four years, as determined by the commissioner. There shall be no inflation adjustment during a year in which a facility's rates are rebased. The commissioner shall determine whether and to what extent a change in ownership of a facility shall occasion the rebasing of the facility's costs.

(10) The method of establishing rates for new facilities shall be determined by the commissioner in accordance with the provisions of this subsection.

(11) There shall be no increase to rates based on inflation or any inflationary factor for the fiscal years ending June 30, 2022, and June 30, 2023, unless otherwise authorized under subdivision (1) of this subsection. Notwithstanding section 17-311-52 of the regulations of Connecticut state agencies, for the fiscal years ending June 30, 2024, and

June 30, 2025, there shall be no inflationary increases to rates beyond those already factored into the model for the transition to an acuity-based reimbursement system. Notwithstanding any other provisions of this chapter, any subsequent increase to allowable operating costs, excluding fair rent, shall be inflated by the gross domestic product deflator when funding is specifically appropriated for such purposes in the enacted budget. The rate of inflation shall be computed by comparing the most recent rate year to the average of the gross domestic product deflator for the previous four fiscal quarters ending March thirty-first. Any increase to rates based on inflation shall be applied prior to the application of any other budget adjustment factors that may impact such rates.

(12) For the fiscal year beginning July 1, 2025, and each fiscal year thereafter, the commissioner shall require a nursing home facility to spend not less than eighty per cent of funding received from Medicaid, Medicare and all other payment sources on direct care of residents, provided the commissioner may adjust the percentage spent on direct care for a nursing home facility with a capital improvement project or a fair rent increase approved by the commissioner. For the fiscal year beginning July 1, 2027, and each fiscal year thereafter, the commissioner may decrease rates of Medicaid reimbursement for any nursing home that does not comply with the provisions of this subdivision. For purposes of this subdivision, (A) "direct care" means hands-on care provided to a facility resident by nursing personnel, including, but not limited to, assistance with feeding, bathing, toileting, dressing, lifting or moving residents, medication administration and salary, fringe benefits and supplies related to direct care; and (B) "nursing personnel" means an advanced practice registered nurse, licensed pursuant to chapter 378, a registered nurse or practical nurse, licensed pursuant to chapter 378, or a nurse's aide, registered pursuant to chapter 378a.

**[**(12)**]** (13) For purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of ninety per cent of capacity, except for facilities that have undergone a change in ownership, new facilities, and facilities which

are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

**[**(13)**]** (14) Rates determined under this section shall comply with federal laws and regulations.

**[**(14)**]** (15) The Commissioner of Social Services may authorize an interim rate for a facility demonstrating circumstances particular to that individual facility impacting facility finances or costs not reflected in the underlying rates.

Sec. 8. (NEW) (*Effective July 1, 2025*) (a) As used in this section, (1) "emergency medical condition" means a medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part; and (2) "emergency Medicaid coverage" means Medicaid coverage for treatment of an emergency medical condition.

(b) The Commissioner of Social Services shall expand emergency Medicaid coverage consistent with federal law for treatment of emergency medical conditions, including, but not limited to, emergency medical conditions related to (1) a high-risk pregnancy, (2) diabetes type 1 in persons under the age of twenty-one, (3) diabetic emergencies, including, but not limited to, diabetic ketoacidosis, (4) renal failure requiring ongoing dialysis, (5) fracture of a bone in the skull, arm, neck, leg, spine or pelvis occurring in the two-month period prior to a request for emergency Medicaid coverage, (6) hypertensive emergencies involving persons presenting with signs or symptoms of end organ damage and systolic blood pressure equaling or exceeding one hundred eighty or diastolic blood pressure equaling or exceeding one hundred twenty, (7) unstable seizure disorder characterized by at least five minutes of uncontrollable seizures or at least two discrete seizures between which the person does not regain consciousness, (8) active

treatment for cancer related to a current diagnosis, (9) ventilator dependency, (10) labor and delivery, and (11) acute inpatient or outpatient psychiatric treatment.

(c) Not later than July 1, 2026, the commissioner shall establish an administrative system for persons to apply in advance for emergency Medicaid coverage for emergency medical conditions that can be treated in outpatient settings rather than in hospital emergency departments. The commissioner shall include a prominent link to the application and a list of covered emergency medical conditions on the Internet web site of the Department of Social Services. The commissioner shall also include information about advance applications for emergency Medicaid coverage and a list of covered emergency medical conditions in department forms and policy manuals.

Sec. 9. (NEW) (*Effective July 1, 2025*) (a) The Commissioner of Social Services shall increase and then eliminate the asset limit for the HUSKY C health program, as defined in section 17b-290 of the general statutes, over a five-year period in accordance with the provisions of this section:

(1) For the fiscal year ending June 30, 2026, the commissioner shall increase the asset limit for (A) an unmarried person from one thousand six hundred dollars to ten thousand dollars, and (B) married persons from two thousand four hundred dollars to fifteen thousand dollars;

(2) For the fiscal year ending June 30, 2027, the commissioner shall increase the asset limit for (A) an unmarried person to twenty-five thousand dollars, and (B) married persons to forty thousand dollars;

(3) For the fiscal year ending June 30, 2028, the commissioner shall increase the asset limit for (A) an unmarried person to seventy-five thousand dollars, and (B) married persons to one hundred thousand dollars;

(4) For the fiscal year ending June 30, 2029, the commissioner shall increase the asset limit for (A) an unmarried person to one hundred

thousand dollars, and (B) married persons to one hundred fifty thousand dollars; and

(5) For the fiscal year ending June 30, 2030, and each fiscal year thereafter, there shall be no asset limit for unmarried or married persons.

(b) The Commissioner of Social Services shall allow any person, whose income exceeds the income limits for the HUSKY C health program but who otherwise qualifies, to qualify for the program by spending down such person's excess income over the program income limits on incurred medical bills in accordance with 42 CFR 435.831.

(c) Not later than July 1, 2026, and annually thereafter until July 1, 2030, the commissioner shall file a report, in accordance with the provisions of section 11-4a of the general statutes, with the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on (1) the number of persons eligible for the HUSKY C health program for the prior fiscal year, and (2) any increased costs incurred by the state that are attributable to changes in the asset limits.

Sec. 10. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "General anesthesia" has the same meaning as provided in section 20-123a of the general statutes; and

(2) "Medical necessity" has the same meaning as provided in section 38a-482a of the general statutes.

(b) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, shall (1) if such policy provides coverage for general anesthesia, (A) impose an arbitrary time limit on reimbursement for general anesthesia provided during any medically necessary procedure, or (B) deny, reduce, terminate or fail to provide such reimbursement, in whole or in part, for general

anesthesia solely because the duration of care exceeded a predetermined time limit as determined by the insurer, or (2) impose unilateral arbitrary limitations on reimbursement for medically necessary ancillary services.

(c) The medical necessity for administering general anesthesia during any medical procedure shall be determined by the attending board-certified anesthesiologist during such medical procedure.

Sec. 11. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "General anesthesia" has the same meaning as provided in section 20-123a of the general statutes; and

(2) "Medical necessity" has the same meaning as provided in section 38a-482a of the general statutes.

(b) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, shall (1) if such policy provides coverage for general anesthesia, (A) impose an arbitrary time limit on reimbursement for general anesthesia provided during any medically necessary procedure, or (B) deny, reduce, terminate or fail to provide such reimbursement, in whole or in part, for general anesthesia solely because the duration of care exceeded a predetermined time limit as determined by the insurer, or (2) impose unilateral arbitrary limitations on reimbursement for medically necessary ancillary services.

(c) The medical necessity for administering general anesthesia during any medical procedure shall be determined by the attending board-certified anesthesiologist during such medical procedure.

Sec. 12. (NEW) (*Effective January 1, 2026*) Any stop loss insurance policy used in conjunction with a self-funded employee health benefit plan shall: (1) Provide coverage for (A) essential health benefits as defined in the Patient Protection and Affordable Care Act, P.L. 111-148,

and regulations adopted thereunder, and (B) the group state-mandated coverage requirements under chapter 700c of the general statutes; or (2) have (A) a minimum individual attachment point of not less than seventy-five thousand dollars, and (B) an aggregate attachment point of not less than two hundred fifty thousand dollars.

Sec. 13. (NEW) (*Effective from passage*) (a) Not later than thirty days after the effective date of this section, the Commissioner of Social Services shall petition the Secretary of the Department of Health and Human Services pursuant to 28 USC 1498, as amended from time to time, to authorize generic, lower cost forms of glucagon-like peptide (GLP-1) prescription drugs approved by the federal Food and Drug Administration to treat obesity or diabetes.

(b) Upon approval of such petition, the commissioner shall enter into a contract with any manufacturer of generic forms of such drugs approved by the federal Food and Drug Administration to supply such drugs to the state for use by HUSKY Health program members. The commissioner may enter into a consortium with officials in other states in contracting with such manufacturer for such drugs.

(c) The commissioner shall develop a strategic plan to maximize access to and minimize the cost of such drugs and, not later than December 31, 2025, submit a report, in accordance with the provisions of section 11-4a of the general statutes, on the plan to the joint standing committee of the General Assembly having cognizance of matters relating to human services and to the advisory committee established pursuant to section 14 of this act.

Sec. 14. (*Effective from passage*) (a) There is established an advisory committee to (1) study ways to maximize access to cost-effective prescription drugs approved by the federal Food and Drug Administration for the treatment of obesity, and (2) make recommendations concerning implementation of the strategic plan developed pursuant to section 13 of this act to the Commissioner of Social Services.

(b) The committee shall consist of the following members:

(1) Two patient advocates appointed by the chairperson of the Council on Medical Assistance Program Oversight, established pursuant to section 17b-28 of the general statutes;

(2) Two pharmacists enrolled as Medicaid providers, appointed by the Commissioner of Social Services; and

(3) Two medical professionals, including at least one doctor certified by the American Board of Obesity Medicine, appointed by the Senate and House chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to human services.

(c) The committee shall be appointed and convene not later than thirty days after the effective date of this section and choose a chairperson. The committee shall meet at least bimonthly.

(d) The committee shall review the strategic plan developed by the Commissioner of Social Services pursuant to section 13 of this act and shall make recommendations to the commissioner on implementation of the plan and the results of its study not later than January 31, 2026. The committee shall terminate upon submission of its recommendations to the commissioner or January 31, 2026, whichever is later.

Sec. 15. Section 17b-278*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

(a) (1) As used in this section, "bariatric surgery" means surgical changes to the digestive system to help a patient with obesity to lose weight;

(2) "Body mass index"<u>, or "BMI",</u> means the number calculated by dividing an individual's weight in kilograms by the individual's height in meters squared;

(3) "Medical services" means (A) prescription drugs approved by the federal Food and Drug Administration for the treatment of obesity on

an outpatient basis, and (B) nutritional counseling provided by a registered dietitian-nutritionist certified pursuant to section 20-206n;

(4) "Severe obesity" means a body mass index that is:

(A) Greater than forty; or

(B) Thirty-five or more if an individual has been diagnosed with a comorbid disease or condition, including, but not limited to, a cardiopulmonary condition, diabetes, hypertension or sleep apnea; **[**and**]**

(5) "Obesity" means a body mass index of thirty or higher; and

(6) "Weight loss drugs" means glucagon-like peptide 1 (GLP-1) prescription drugs approved by the federal Food and Drug Administration for weight loss or commonly used for weight loss, sleep apnea or to reduce risks of cardiovascular disease.

(b) The Commissioner of Social Services shall provide medical assistance for (1) bariatric surgery and related medical services for Medicaid and HUSKY B beneficiaries with severe obesity, and (2) medical services for Medicaid and HUSKY B beneficiaries with a body mass index greater than thirty-five, **[**provided such beneficiaries otherwise meet conditions set by the Centers for Medicare and Medicaid Services for such surgery and medical services**]** including weight loss drugs. The commissioner shall continue to provide Medicaid coverage for beneficiaries treated with weight loss drugs if their BMI drops below thirty-five and a licensed physician certifies, in writing, that their BMI would increase above thirty-five if such drugs were discontinued. If necessary, the commissioner may amend the Medicaid state plan and the state plan for the Children's Health Insurance Program to implement the provisions of this section.

Sec. 16. Section 38a-479ttt of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

Not later than March 1, 2021, and annually thereafter, the

commissioner shall prepare a report, for the immediately preceding calendar year, describing the rebate practices of health carriers. The report shall contain (1) an explanation of the manner in which health carriers accounted for rebates in calculating premiums for health care plans delivered, issued for delivery, renewed, amended or continued during such year, (2) a statement disclosing whether, and describing the manner in which, health carriers made rebates available to insureds at the point of purchase during such year, (3) any other manner in which health carriers applied rebates during such year, (4) the percentage of rebate dollars used by health carriers to reduce cost-sharing requirements during such year, (5) an evaluation of rebate practices to reduce cost-sharing for health care plans delivered, issued for delivery, renewed, amended or continued during such year, and **[**(4)**]** (6) such other information as the commissioner, in the commissioner's discretion, deems relevant for the purposes of this section. The commissioner shall publish a copy of the report on the department's Internet web site.

Sec. 17. (NEW) (*Effective from passage*) As used in this section and section 18 of this act:

(1) "340B drug" means a drug that (A) is a covered outpatient drug within the meaning of 42 USC 256b; (B) has been subject to any offer for reduced prices by a manufacturer under 42 USC 256b(a)(1); and (C) is purchased by a covered entity. "340B drug" includes a drug that would have been purchased but for the restriction or limitation described in subsection (a) of section 18 of this act;

(2) "Biologic" has the same meaning as provided in section 21a-70d of the general statutes;

(3) "Covered entity" means The University of Connecticut Health Center, a federally qualified health center, a family planning clinic and a Ryan White clinic;

(4) "Manufacturer" has the same meaning as provided in section 21a-70 of the general statutes, except that such definition shall include

manufacturers of biologics;

(5) "Package" has the same meaning as provided in 21 USC 360eee(11)(A); and

(6) "Pharmacy" has the same meaning as provided in section 20-571 of the general statutes.

Sec. 18. (NEW) (*Effective from passage*) (a) A manufacturer, or an agent or affiliate of such manufacturer, shall not, either directly or indirectly:

(1) Deny, restrict, prohibit, discriminate against or otherwise limit the acquisition of a 340B drug by, or delivery of a 340B drug to, a pharmacy that is under contract with, or otherwise authorized by, a covered entity to receive 340B drugs on behalf of the covered entity unless such receipt is prohibited under federal law; or

(2) Require a covered entity, or a pharmacy that is under contract with a covered entity, to submit any claims or utilization data as a condition for allowing the acquisition of a 340B drug by, or delivery of a 340B drug to, a covered entity, or a pharmacy that is under contract with a covered entity, unless the claims or utilization data sharing is required by the United States Department of Health and Human Services.

(b) (1) On and after July 1, 2025, if the Commissioner of Consumer Protection receives information and has a reasonable belief, after evaluating such information, that any manufacturer, or an agent or affiliate of such manufacturer, has acted in violation of any provision of this section or regulation adopted thereunder, such manufacturer, or an agent or affiliate of such manufacturer, shall be subject to a civil penalty of not more than fifty thousand dollars for each violation. The commissioner shall issue a notice of violation and civil penalty and may issue such notice by first-class mail or personal service. Such notice shall include: (A) A reference to the section of the general statutes or regulation of Connecticut state agencies believed or alleged to have been violated; (B) a short and plain-language statement of the matters

asserted or charged; (C) a description of the activity to cease; (D) a statement of the amount of the civil penalty or penalties that may be imposed; (E) a statement concerning the right to a hearing; and (F) a statement that such manufacturer, or an agent or affiliate of such manufacturer, may, not later than ten business days after receipt of such notice, make a request for a hearing on the matters asserted.

(2) The manufacturer, or an agent or affiliate of such manufacturer, to whom such notice is provided pursuant to subparagraph (A) of subdivision (1) of this subsection may, not later than ten business days after receipt of such notice, make written application to the Department of Consumer Protection to request a hearing to demonstrate that such violation did not occur. The failure to make a timely request for a hearing shall result in the issuance of a cease and desist order or imposition of a civil penalty by the department. All hearings held under this subsection shall be conducted in accordance with the provisions for contested cases under chapter 54 of the general statutes.

(3) Following any hearing before the Department of Consumer Protection pursuant to subdivision (2) of this subsection, if the department finds, by a preponderance of the evidence, that any manufacturer, or an agent or affiliate of such manufacturer, violated or is violating any provision of this subsection, any regulation adopted thereunder or any order issued by the department, the department shall issue a final cease and desist order in addition to any civil penalty the department imposes.

(c) Nothing in this section shall be construed or applied to be in conflict with or less restrictive than:

(1) Applicable federal law and related regulations, including 21 USC 355-1, as amended from time to time; or

(2) Other laws of this state to the extent such laws are compatible with applicable federal law.

(d) The Commissioner of Consumer Protection shall adopt

regulations in accordance with the provisions of chapter 54 of the general statutes to implement the provisions of this section.

Sec. 19. (NEW) (*Effective July 1, 2025*) (a) As used in this section, "pay to delay" means an agreement between a pharmaceutical manufacturer and a competitor to delay the launch of a generic drug based on an expiring or expired patent for a drug made by the pharmaceutical manufacturer.

(b) A pharmaceutical manufacturer doing business in this state shall annually report to the Commissioner of Consumer Protection any "pay to delay" agreements such manufacturer has with any competitor and the prescription drugs included in such agreement. A pharmaceutical manufacturer shall make such reports in a form and manner prescribed by the commissioner.

(c) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section and may establish penalties and an administrative hearing process in accordance with chapter 54 of the general statutes for a pharmaceutical manufacturer that violates the provisions of this section.

Sec. 20. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "Health benefit plan" has the same meaning as provided in section 38a-472f of the general statutes;

(2) "Insulin" means an insulin product, including, but not limited to, an insulin pen or vial, that is licensed under 42 USC 262(a) or 42 USC 262(k), as amended from time to time;

(3) "Eligible insulin product" means an insulin product for which at least two licenses have been issued and continues to be marketed pursuant to such licensure;

(4) "Net cost" means the cost of an insulin product taking into account rebates or discounts for that specific product, excluding (A) rebates or

discounts required by state or federal law, including Medicaid, Medicare and Section 340B of the Public Health Service Act, 42 USC 256b, as amended from time to time, and (B) rebates or discounts related to portfolio agreements that relate to purchase of multiple insulin products or other drugs;

(5) "State entity" means any state agency, or any person acting on behalf of the state, that purchases a prescription drug for an individual 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;

(6) "Wholesale acquisition cost" means the price of a medication set by a pharmaceutical manufacturer in the United States when selling to a wholesaler; and

(7) "Wholesaler" means a wholesaler, as defined in section 21a-70 of the general statutes, that has received a certificate of registration from the Commissioner of Consumer Protection pursuant to said section.

(b) A state entity and health benefit plan shall, except as otherwise required in any collective bargaining agreement affecting the state employee health plan established pursuant to section 5-259 of the general statutes, make available in a preferred tier with no copayment or out-of-pocket cost an eligible insulin product at the lowest wholesale acquisition cost to a beneficiary. Notwithstanding the provisions of this section, if a state entity or health benefit plan determines that another eligible insulin product has a lower net cost than the lowest wholesale acquisition cost, such entity or health plan may offer that product with no out-of-pocket payment to a beneficiary of such state entity or health benefit plan. Nothing in this section shall prevent such entity or health benefit plan from covering more than one eligible insulin product in a preferred tier with no copayment or out-of-pocket cost to a beneficiary of such entity or health benefit plan.

Sec. 21. Section 38a-492d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) For the purposes of this section:

(1) "Diabetes device" has the same meaning as provided in section 20-616;

(2) "Diabetic ketoacidosis device" has the same meaning as provided in section 20-616;

(3) "Glucagon drug" has the same meaning as provided in section 20-616;

(4) "High deductible health plan" has the same meaning as that term is used in subsection (f) of section 38a-493;

(5) "Insulin drug" has the same meaning as provided in section 20-616;

(6) "Noninsulin drug" means a drug, including, but not limited to, a glucagon drug, glucose tablet or glucose gel, that does not contain insulin and is approved by the federal Food and Drug Administration to treat diabetes; and

(7) "Prescribing practitioner" has the same meaning as provided in section 20-571.

(b) Notwithstanding the provisions of section 38a-492a, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the treatment of all types of diabetes. Such coverage shall include, but need not be limited to, coverage for medically necessary:

(1) Laboratory and diagnostic testing and screening, including, but not limited to, hemoglobin A1c testing and retinopathy screening, for all types of diabetes;

(2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616

once during a policy year;

(3) Noninsulin drugs (A) prescribed by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year if the noninsulin drug is a glucagon drug;

(4) Diabetes devices in accordance with the insured's diabetes treatment plan, including, but not limited to, diabetes devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year; and

(5) Diabetic ketoacidosis devices in accordance with the insured's diabetes treatment plan, including, but not limited to, diabetic ketoacidosis devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year.

(c) Notwithstanding the provisions of section 38a-492a, no policy described in subsection (b) of this section shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses on an insured that exceed:

(1) Twenty-five dollars for each thirty-day supply of a medically necessary covered insulin drug (A) prescribed to the insured by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year;

(2) Twenty-five dollars for each thirty-day supply of a medically necessary covered noninsulin drug (A) prescribed to the insured by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year if such noninsulin drug is a glucagon drug;

(3) One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan, including, but not limited to, diabetes devices and diabetic ketoacidosis devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year.

(d) Notwithstanding the provisions of subsection (c) of this section and section 38a-492a, on and after January 1, 2026, any policy described in subsection (b) of this section shall make available in a preferred tier with no copayment or out-of-pocket cost an eligible insulin product, as defined in section 20 of this act, at the lowest wholesale acquisition cost in accordance with section 20 of this act.

**[**(d)**]** (e) The provisions of **[**subsection (c)**]** subsections (c) and (d) of this section shall apply to a high deductible health plan to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of said **[**subsection (c)**]** subsections shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

Sec. 22. Section 38a-518d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) For the purposes of this section:

(1) "Diabetes device" has the same meaning as provided in section 20-616;

(2) "Diabetic ketoacidosis device" has the same meaning as provided in section 20-616;

(3) "Glucagon drug" has the same meaning as provided in section 20-616;

(4) "High deductible health plan" has the same meaning as that term is used in subsection (f) of section 38a-520;

(5) "Insulin drug" has the same meaning as provided in section 20-

616;

(6) "Noninsulin drug" means a drug, including, but not limited to, a glucagon drug, glucose tablet or glucose gel, that does not contain insulin and is approved by the federal Food and Drug Administration to treat diabetes; and

(7) "Prescribing practitioner" has the same meaning as provided in section 20-571.

(b) Notwithstanding the provisions of section 38a-518a, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the treatment of all types of diabetes. Such coverage shall include, but need not be limited to, coverage for medically necessary:

(1) Laboratory and diagnostic testing and screening, including, but not limited to, hemoglobin A1c testing and retinopathy screening, for all types of diabetes;

(2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year;

(3) Noninsulin drugs (A) prescribed by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year if the noninsulin drug is a glucagon drug;

(4) Diabetes devices in accordance with the insured's diabetes treatment plan, including, but not limited to, diabetes devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year; and

(5) Diabetic ketoacidosis devices in accordance with the insured's diabetes treatment plan, including, but not limited to, diabetic ketoacidosis devices prescribed and dispensed pursuant to subsection

(d) of section 20-616 once during a policy year.

(c) Notwithstanding the provisions of section 38a-518a, no policy described in subsection (b) of this section shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses on an insured that exceed:

(1) Twenty-five dollars for each thirty-day supply of a medically necessary covered insulin drug (A) prescribed to the insured by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year;

(2) Twenty-five dollars for each thirty-day supply of a medically necessary covered noninsulin drug (A) prescribed to the insured by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year if such noninsulin drug is a glucagon drug;

(3) One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan, including, but not limited to, diabetes devices and diabetic ketoacidosis devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year.

(d) Notwithstanding the provisions of subsection (c) of this section and section 38a-518a, on and after January 1, 2026, any policy described in subsection (b) of this section shall make available in a preferred tier with no copayment or out-of-pocket cost an eligible insulin product, as defined in section 20 of this act, at the lowest wholesale acquisition cost in accordance with section 20 of this act.

**[**(d)**]** (e) The provisions of **[**subsection (c)**]** subsections (c) and (d) of this section shall apply to a high deductible health plan to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding

internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of said [subsection (c)] subsections shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

Sec. 23. (NEW) (*Effective October 1, 2025*) (a) Any pharmacy benefits manager shall owe a fiduciary duty to any health carrier, as defined in section 38a-591a of the general statutes, or other health benefit plan sponsor.

(b) Any pharmacy benefits manager shall notify the health carrier or other health benefit plan sponsor, in writing, of any activity, policy or practice of such pharmacy benefits manager that directly or indirectly presents any conflict of interest with the duties imposed by this section.

(c) Any pharmacy benefits manager shall have an obligation of good faith and fair dealing in performing such pharmacy benefits manager's duties with all parties, including, but not limited to, a health carrier or other health benefit plan sponsor with whom such pharmacy benefits manager interacts in the performance of pharmacy benefit management services.

(d) Notwithstanding any provision of title 38a of the general statutes and to the maximum extent permitted by applicable law, no contract entered into or amended by a health carrier shall contain any provision that permits or requires any party to such contract to violate the fiduciary duty that such health carrier owes to such health carrier's covered persons.

(e) Any violation of the provisions of this section shall constitute a violation of sections 38a-815 to 38a-819, inclusive, of the general statutes.

(f) The Insurance Commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to

implement the provisions of this section.

Sec. 24. Section 38a-477cc of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) No contract for pharmacy services entered into in the state between a health carrier, as defined in section 38a-591a, or pharmacy benefits manager, as defined in section 38a-479aaa, and a pharmacy or pharmacist shall:

(1) On and after January 1, 2018, contain a provision prohibiting or penalizing, including through increased utilization review, reduced payments or other financial disincentives, a pharmacist's disclosure to an individual purchasing prescription medication of information regarding:

(A) The cost of the prescription medication to the individual; or

(B) The availability of any therapeutically equivalent alternative medications or alternative methods of purchasing the prescription medication, including, but not limited to, paying a cash price, that are less expensive than the cost of the prescription medication to the individual; **[**and**]**

(2) On and after January 1, 2020, contain a provision permitting the health carrier or pharmacy benefits manager to recoup, directly or indirectly, from a pharmacy or pharmacist any portion of a claim that such health carrier or pharmacy benefits manager has paid to the pharmacy or pharmacist, unless such recoupment is permitted under section 38a-479iii or required by applicable law;

(3) On and after January 1, 2026, contain a provision permitting the pharmacy benefits manager to charge a health benefit plan in this state a contracted price for any pharmacy services that differs from the amount such pharmacy benefits manager, directly or indirectly, pays the pharmacy for such pharmacy services; and

(4) On and after January 1, 2026, contain a provision permitting the

pharmacy benefits manager to charge a health benefit plan, directly or indirectly, a fee that is conditioned on the (A) wholesale acquisition cost or any other price metric for a prescription drug, (B) amount of savings, rebates or other fees charged, realized, collected by or generated based on the business practices of such pharmacy benefits manager, or (C) amount of premiums charged or cost-sharing requirements pursuant to such health benefit plan that are realized or collected by such pharmacy benefits manager from covered persons. For the purposes of this subdivision, "wholesale acquisition cost" means the price of a medication set by a pharmaceutical manufacturer in the United States when selling to a wholesaler.

(b) (1) On and after January 1, 2018, no health carrier or pharmacy benefits manager shall require an individual to make a payment at the point of sale for a covered prescription medication in an amount greater than the lesser of:

(A) The applicable copayment for such prescription medication;

(B) The allowable claim amount for the prescription medication; or

(C) The amount an individual would pay for the prescription medication if the individual purchased the prescription medication without using a health benefit plan, as defined in section 38a-591a, or any other source of prescription medication benefits or discounts.

(2) For the purposes of this subsection, "allowable claim amount" means the amount the health carrier or pharmacy benefits manager has agreed to pay the pharmacy for the prescription medication.

(c) Any provision of a contract that violates the provisions of this section shall be void and unenforceable. Any general business practice that violates the provisions of this section shall constitute an unfair trade practice pursuant to chapter 735a. The invalidity or unenforceability of any contract provision under this subsection shall not affect any other provision of the contract.

(d) The Insurance Commissioner may:

(1) Enforce the provisions of this section pursuant to chapter 697; and

(2) Upon request, audit a contract for pharmacy services for compliance with the provisions of this section.

Sec. 25. (NEW) (*Effective July 1, 2025*) (a) The Insurance Commissioner shall require any health carrier, as defined in section 38a-591a of the general statutes, to report to the commissioner annually on pricing offered to and profit generated between such carrier and any pharmacy benefits manager or mail-order pharmacy doing business with such carrier.

(b) The commissioner shall post a link on the Internet web site of the Insurance Department to the reports filed pursuant to subsection (a) of this section.

Sec. 26. (*Effective July 1, 2025*) For the purposes of this section and sections 27 to 35, inclusive, of this act, unless the context otherwise requires:

(1) "Canadian supplier" means a manufacturer or wholesale drug distributor that is licensed or permitted under applicable Canadian law to manufacture or distribute prescription drugs;

(2) "Canadian prescription drug importation program" or "program" means a program under which the state would seek federal approval to import prescription drugs from Canada that have the highest potential for cost savings in the state;

(3) "Department" means the Department of Consumer Protection;

(4) "Drug" means an article that is (A) recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement thereto, (B) intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans, (C) not food and intended to affect the structure or any function of the human body, and (D) not a device and intended for use as a component of any article specified in

subparagraphs (A) to (C), inclusive, of this subdivision;

(5) "Drug Quality and Security Act" means the federal Drug Quality and Security Act, 21 USC 351, et seq., as amended from time to time;

(6) "Food, Drug and Cosmetic Act" means the federal Food, Drug and Cosmetic Act, 21 USC 301, et seq., as amended by the Drug Quality and Security Act, as both may be amended from time to time;

(7) "Qualifying laboratory" has the same meaning as provided in 21 CFR 251.2;

(8) "Laboratory testing" means a quantitative and qualitative analysis of a drug consistent with the applicable provisions of the official United States Pharmacopoeia;

(9) "Participating Canadian supplier" means a Canadian supplier that is exporting prescription drugs, in the manufacturer's original container, to a participating wholesaler for distribution in this state under the program;

(10) "Participating wholesaler" means a wholesaler that is (A) designated by the Department of Consumer Protection to distribute prescription drugs in the manufacturer's original container, obtained from a participating Canadian supplier, and (B) participating in the program;

(11) "Recall" means a person's removal or correction of a marketed product that the department determines is in violation of this section, but "recall" does not include a market withdrawal or a stock recovery, as such terms are defined in 21 CFR 7.3;

(12) "Relabeler" has the same meaning as provided in 21 CFR 207.1;

(13) "Repacker" has the same meaning as provided in 21 CFR 207.1;

(14) "Track-and-trace" means the product tracing process for the components of the pharmaceutical distribution supply chain as described in Title II of the Drug Quality and Security Act; and

(15) "Wholesaler" means a wholesaler, as defined in section 21a-70 of the general statutes, that has received a certificate of registration from the Commissioner of Consumer Protection pursuant to said section.

Sec. 27. (*Effective July 1, 2025*) The Commissioner of Consumer Protection shall hire, within available resources, a consultant to study the feasibility of establishing a Canadian prescription drug importation program to reduce prescription drug costs in the state. Not later than October 1, 2027, the commissioner shall file a report, in accordance with the provisions of section 11-4a of the general statutes, with the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, general law and human services and the Office of Policy and Management on the results of the feasibility study.

Sec. 28. (*Effective October 1, 2027*) (a) If after completion of the study described in section 27 of this act, the Commissioner of Consumer Protection, in consultation with the Secretary of the Office of Policy and Management, determines a Canadian prescription drug importation program is feasible, the Commissioner of Consumer Protection may submit a request to the federal Food and Drug Administration seeking approval for the program under Section 804 of the federal Food, Drug and Cosmetic Act, 21 USC 384(b) to 21 USC 384(h), inclusive, as amended from time to time. If submitted, such request shall, at a minimum:

(1) Describe the state's plans for operating the program and describe any opportunities to coordinate or operate the program in coordination with other states;

(2) Demonstrate that any prescription drug that is imported and distributed in this state under the program would:

(A) Meet all applicable federal and state standards for safety and effectiveness; and

(B) Comply with all federal tracing procedures; and

(3) State the estimated costs of implementing the program.

(b) If the federal Food and Drug Administration approves the request, the Commissioner of Consumer Protection shall:

(1) Submit to the Secretary of the Office of Policy and Management, and the Commissioners of Social Services and Health Strategy, a notice disclosing that the federal Food and Drug Administration approved such request; and

(2) Submit to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, general law, human services and public health a notice disclosing that the federal Food and Drug Administration approved such request.

(c) The Commissioner of Consumer Protection shall not operate the program unless the federal Food and Drug Administration approves the request. Notwithstanding the provisions of this subsection, the department may expend resources in advance of such approval to ensure efficient implementation.

Sec. 29. (*Effective October 1, 2027*) If the Canadian prescription drug importation program is established, each participating wholesaler may import and distribute a prescription drug in this state from a participating Canadian supplier under the program if:

(1) Such drug meets the federal Food and Drug Administration's standards concerning drug safety, effectiveness, misbranding and adulteration;

(2) Importing such drug would not violate federal patent laws; and

(3) Such drug is not:

(A) A controlled substance, as defined in 21 USC 802, as amended from time to time;

(B) A biological product, as defined in 42 USC 262, as amended from

time to time;

(C) An infused drug;

(D) An intravenously injected drug;

(E) A drug that is inhaled during surgery; or

(F) A drug that is a parenteral drug, the importation of which is determined by the federal Secretary of Health and Human Services to pose a threat to the public health.

Sec. 30. (*Effective October 1, 2027*) If a Canadian prescription drug importation program is established, participating wholesalers may, subject to the provisions of sections 31 and 32 of this act, import and distribute drugs in this state from a participating Canadian supplier under the program to:

(1) A pharmacy or institutional pharmacy, as defined in section 20-571 of the general statutes; and

(2) A qualifying laboratory.

Sec. 31. (*Effective October 1, 2027*) If a Canadian prescription drug importation program is established, the Commissioner of Consumer Protection shall require that each participating Canadian supplier and participating wholesaler (1) comply with all applicable track-and-trace requirements, and shall not distribute, dispense or sell outside of this state any prescription drug that is imported into this state under the program, and (2) make available to the commissioner all track-and-trace records not later than forty-eight hours after the commissioner requests such records.

Sec. 32. (*Effective October 1, 2027*) (a) A participating wholesaler in any approved Canadian prescription drug importation program shall ensure the safety and quality of all drugs that may be imported and distributed in this state under the program. The participating wholesaler shall, if such program is established:

(1) For each initial shipment of a drug that is imported into this state by a participating wholesaler, ensure that a qualifying laboratory engaged by the participating wholesaler tests a statistically valid sample size for each batch of each drug in such shipment for authenticity and degradation in a manner that is consistent with the Food, Drug and Cosmetic Act;

(2) For each shipment of a drug that is imported into this state by a participating wholesaler and has been sampled and tested pursuant to subdivision (1) of this subsection, ensure that a qualifying laboratory engaged by the participating wholesaler tests a statistically valid sample of such shipment for authenticity and degradation in a manner that is consistent with the Food, Drug and Cosmetic Act;

(3) Only import drugs into this state that are (A) approved for marketing in the United States, (B) not adulterated or misbranded, and (C) meet all of the labeling requirements under 21 USC 352, as amended from time to time;

(4) Maintain qualifying laboratory records, including, but not limited to, complete data derived from all tests necessary to ensure that each drug imported into this state under any approved Canadian prescription drug importation program is in compliance with the requirements of this section; and

(5) Maintain documentation demonstrating that the testing required by this section was conducted at a qualifying laboratory in accordance with the Food, Drug and Cosmetic Act and all other applicable federal and state laws and regulations concerning qualifying laboratory qualifications.

(b) The participating wholesaler shall maintain all information and documentation pursuant to this section for a period of not less than three years from the date of submission of such information and documentation to the participating wholesaler by a qualifying laboratory.

(c) Each participating wholesaler shall maintain all of the following information for each drug that such participating wholesaler imports and distributes in this state under the program, and submit such information to the Commissioner of Consumer Protection upon request by the commissioner:

(1) The name and quantity of the active ingredient of such drug;

(2) A description of the dosage form of such drug;

(3) The date on which such participating wholesaler received such drug;

(4) The quantity of such drug that such participating wholesaler received;

(5) The point of origin and destination of such drug;

(6) The price paid by such participating wholesaler for such drug;

(7) A report regarding any drug that fails qualifying laboratory testing; and

(8) Such additional information and documentation that the commissioner deems necessary to ensure the protection of the public health.

(d) The Commissioner of Consumer Protection shall require each participating Canadian supplier in any approved Canadian prescription drug importation program to maintain the following information and documentation and, upon request by the commissioner, submit such information and documentation to the commissioner for each drug that such participating Canadian supplier exports into this state under the program:

(1) The original source of such drug, including, but not limited to:

(A) The name of the manufacturer of such drug;

(B) The date on which such drug was manufactured; and

(C) The location where such drug was manufactured;

(2) The date on which such drug was shipped;

(3) The quantity of such drug that was shipped;

(4) The quantity of each lot of such drug originally received and the source of such lot;

(5) The lot or control number and the batch number assigned to such drug by the manufacturer; and

(6) Such additional information and documentation that the Commissioner of Consumer Protection deems necessary to ensure the protection of the public health.

Sec. 33. (*Effective October 1, 2027*) (a) If the Commissioner of Consumer Protection determines that public health, safety or welfare requires emergency action, the commissioner may order a participating Canadian supplier, participating wholesaler, relabeler, repacker and qualifying laboratory to cease and desist from actions specified in the order that create the need for such emergency action pending administrative proceedings. Such cease and desist order shall be (1) in writing; (2) signed by the Commissioner of Consumer Protection; and (3) effective upon delivery to the respondent. An administrative proceeding in accordance with chapter 54 of the general statutes shall be promptly instituted following a cease and desist order. The commissioner may impose a civil penalty, in an amount not to exceed ten thousand dollars, after a hearing conducted pursuant to chapter 54 of the general statutes.

(b) The commissioner may require the recall, embargo or destruction, pursuant to section 21a-96 of the general statutes, of any drug that was imported and distributed under the program and has been identified as adulterated, within the meaning of section 21a-105 of the general statutes, or misbranded.

(c) In the event of a cease and desist, recall, embargo or destruction order, the person adversely impacted by such order shall provide written notice to all other businesses participating in the program, informing them of the order.

Sec. 34. (*Effective October 1, 2027*) If a Canadian prescription drug importation program is established, the Commissioner of Consumer Protection may adopt regulations in accordance with the provisions of chapter 54 of the general statutes to implement the provisions of sections 29 to 33, inclusive, of this act.

Sec. 35. (*Effective October 1, 2027*) Not later than one hundred eighty days after the first importation of any Canadian prescription drug under the importation program begins, and biannually thereafter, the Commissioner of Consumer Protection shall submit 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 appropriations and the budgets of state agencies, general law, human services and public health. Such report shall describe (1) the operation of the program, if established, and (2) any violation of sections 29 to 33, inclusive, of this act that resulted in any action taken by the commissioner pursuant to section 33 of this act and the status of the investigation into such violation.

Sec. 36. (NEW) (*Effective from passage*) (a) There is established a task force to study emergency preparedness and mitigation strategies for prescription drug shortages. The task force shall identify prescription drugs at risk of shortage in this state and make recommendations pursuant to subsection (g) of this section.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom has expertise in prescription drug supply chains and one of whom has expertise in federal law concerning prescription drug shortages;

(2) Two appointed by the president pro tempore of the Senate, one of whom represents hospitals and one of whom represents health care providers who treat patients with rare diseases;

(3) One appointed by the majority leader of the House of Representatives, who represents one of the two federally recognized Indian tribes in the state;

(4) One appointed by the majority leader of the Senate, who represents one of the two federally recognized Indian tribes in the state;

(5) One appointed by the minority leader of the House of Representatives;

(6) One appointed by the minority leader of the Senate;

(7) The Commissioner of Health Strategy, or the commissioner's designee;

(8) The Commissioner of Consumer Protection, or the commissioner'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 chief executive officer of The University of Connecticut Health Center, or the chief executive officer's designee;

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

(13) The Commissioner of Economic and Community Development, or the commissioner's designee.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member

of the General Assembly.

(d) All initial appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to human services shall serve as administrative staff of the task force.

(g) Not later than January 1, 2026, and annually thereafter, the task force shall submit a report on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to general law, human services, insurance and real estate and public health, in accordance with the provisions of section 11-4a of the general statutes, including, but not limited to, identification of prescription drugs the task force determines are at risk of shortage and strategies that would mitigate these shortages, including methods to increase in-state production of such drugs deemed both at risk of shortage and critically necessary for the provision of health care within the state.

Sec. 37. (NEW) *(Effective July 1, 2025*) (a) As used in this section, "Strategic Supply Chain Initiative" means a program administered by the Department of Economic and Community Development to help state-based companies to increase their production capacity to win new business and attract out-of-state and international supply chain operations.

(b) The Commissioner of Economic and Community Development shall expand the Strategic Supply Chain Initiative to include efforts to

prevent or mitigate prescription drug shortages, including, but not limited to, incorporating recommendations to prevent or mitigate prescription drug shortages by the task force established pursuant to section 36 of this act.

Sec. 38. (NEW) (*Effective from passage*) (a) The Commissioner of Public Health shall establish and convene a Vaccines and Related Biological Products Advisory Committee for the purpose of coordinating seasonal vaccine production in coordination with pharmaceutical drug manufacturers.

(b) The commissioner shall appoint to the advisory committee representatives of (1) pharmaceutical manufacturers, including one large such manufacturer and one small or start-up such manufacturer; (2) health systems, including, but not limited to, one large or state-wide hospital system and one federally qualified health center; and (3) physicians, including, but not limited to, one expert each in infectious disease epidemiology, disease ecology, biostatistics or infectious disease modeling, and an expert in immunology or virology.

(c) The advisory committee shall be appointed and meet not later than thirty days after the effective date of this act. The chairpersons shall be the commissioner, or the commissioner's designee, and a member of the committee elected by the committee. Any vacancy shall be filled by the commissioner.

(d) Not later than September 1, 2025, and annually thereafter, the commissioner shall file a report, in accordance with the provisions of section 11-4a of the general statutes, with the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health on the activities and recommendations of the advisory committee and impact on state preparedness for the annual flu season.

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

| | | |
|---|---|---|
| Section 1 | *July 1, 2025* | New section |
| Sec. 2 | *July 1, 2025* | New section |
| Sec. 3 | *July 1, 2025* | New section |
| Sec. 4 | *July 1, 2025* | New section |
| Sec. 5 | *July 1, 2025* | New section |
| Sec. 6 | *from passage* | New section |
| Sec. 7 | *July 1, 2025* | 17b-340d(a) |
| Sec. 8 | *July 1, 2025* | New section |
| Sec. 9 | *July 1, 2025* | New section |
| Sec. 10 | *January 1, 2026* | New section |
| Sec. 11 | *January 1, 2026* | New section |
| Sec. 12 | *January 1, 2026* | New section |
| Sec. 13 | *from passage* | New section |
| Sec. 14 | *from passage* | New section |
| Sec. 15 | *July 1, 2025* | 17b-278*l* |
| Sec. 16 | *October 1, 2025* | 38a-479ttt |
| Sec. 17 | *from passage* | New section |
| Sec. 18 | *from passage* | New section |
| Sec. 19 | *July 1, 2025* | New section |
| Sec. 20 | *January 1, 2026* | New section |
| Sec. 21 | *January 1, 2026* | 38a-492d |
| Sec. 22 | *January 1, 2026* | 38a-518d |
| Sec. 23 | *October 1, 2025* | New section |
| Sec. 24 | *January 1, 2026* | 38a-477cc |
| Sec. 25 | *July 1, 2025* | New section |
| Sec. 26 | *July 1, 2025* | New section |
| Sec. 27 | *July 1, 2025* | New section |
| Sec. 28 | *October 1, 2027* | New section |
| Sec. 29 | *October 1, 2027* | New section |
| Sec. 30 | *October 1, 2027* | New section |
| Sec. 31 | *October 1, 2027* | New section |
| Sec. 32 | *October 1, 2027* | New section |
| Sec. 33 | *October 1, 2027* | New section |
| Sec. 34 | *October 1, 2027* | New section |
| Sec. 35 | *October 1, 2027* | New section |
| Sec. 36 | *from passage* | New section |
| Sec. 37 | *July 1, 2025* | New section |
| Sec. 38 | *from passage* | New section |

***Statement of Legislative Commissioners:***

In Section 2(b)(1), "Commissioner of Consumer Protection" was changed to "Commissioner of Revenue Services" for accuracy; in Section 2(c)(1)(A)(i), "Commissioner of Consumer Protection" was changed to "commissioner" for accuracy; in Section 4(a), "section 5" was changed to "sections 5 and 6" for accuracy; in Sections 4(b) and 6, "executive director" was changed to "chief executive officer" for accuracy; in Section 5(b), "or section 4 of this act" was inserted for accuracy; in Section 6, the effective date was changed for accuracy; in Section 6(f), a reference to "task force" was changed to "council" for consistency; in Section 14(a)(2), "concerning implementation of the strategic plan developed pursuant to section 13 of this act" was inserted after "recommendations" for clarity; in Section 22(d), the statutory citation was changed for accuracy; in Section 23(e), "the Connecticut Unfair Insurance Practices Act established pursuant to section" was changed to "sections 38a-815 to 38a-819, inclusive," for clarity; and in Section 28(c), "foregoing" was changed to "provisions of this subsection" for consistency with standard drafting conventions.

***HS*** *Joint Favorable Subst.*

*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 26 $ | FY 27 $ |
|---|---|---|---|
| Social Services, Dept. | GF - Cost | at least $97 million | at least $185 million |
| Consumer Protection, Dept. | GF - Cost | 373,552 | 266,052 |
| Public Health, Dept. | GF - Cost | 134,700 | 130,750 |
| Department of Revenue Services | GF - Cost | 32,990 | 131,958 |
| Consumer Protection, Dept. | GF - Potential Cost | None | 84,010 |
| State Comptroller - Fringe Benefits[1] | GF - Cost | 208,383 | 248,673 |
| State Comptroller - Fringe Benefits | GF - Potential Cost | See Below | At least 31,147 |
| Social Services, Dept. | GF - Revenue Gain | at least 125,000 | See Below |
| Resources of the General Fund | GF - Potential Revenue Gain | See Below | See Below |
| Correction, Dept.; Judicial Dept. (Probation) | GF - Potential Cost | Minimal | Minimal |
| Treasurer, Debt Serv. | GF - Potential Cost | See Below | See Below |
| Social Services, Dept. | GF - Potential Savings | See Below | See Below |
| UConn Health Ctr. | GF - Potential Savings | See Below | See Below |
| Various State Agencies | GF - Potential Savings | See Below | See Below |

Note: GF=General Fund

### *Municipal Impact:*

| Municipalities | Effect | FY 26 $ | FY 27 $ |
|---|---|---|---|
| Various Municipalities | Cost | Potential | Potential |

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 40.71% of payroll in FY 26.

***Explanation***

The bill makes various changes regarding prescription drugs resulting in the impacts described below.

**Sections 1 and 2** establish a prescription drug cost containment initiative to be administered by the Department of Revenue Services (DRS). This results in a General Fund cost of $46,420 in FY 26 (partial year) and $185,678 in FY 27. The cost is associated with two Revenue Examiner positions within DRS to administer the program ($65,979 and $26,860 each for salary and fringe benefit costs, respectively).

Section 2 imposes a civil penalty for violation of the price cap provision which results in a potential General Fund revenue gain beginning in FY 26, the magnitude of which is dependent on the violator's price differential in excess of the price cap.

Section 2 also creates a new class D felony for willfully providing certain false or fraudulent material, which results in a potential cost to the Department of Correction and the Judicial Department for incarceration or probation and a potential revenue gain to the General Fund from fines. On average, the marginal cost to the state for incarcerating an offender for the year is $3,300[2] while the average marginal cost for supervision in the community is less than $600[3] each year for adults.

**Sections 3 and 19** make requirements regarding withdrawing a prescription drug from sale in the state and requiring a manufacturer to report pay to delay agreements resulting in a cost to the Department of Consumer Protection (DCP). To meet the requirements of these sections DCP will need to hire one processing technician for a salary and other

[2]Inmate marginal cost is based on increased consumables (e.g., food, clothing, water, sewage, living supplies, etc.) This does not include a change in staffing costs or utility expenses because these would only be realized if a unit or facility opened.

[3]Probation marginal cost is based on services provided by private providers and only includes costs that increase with each additional participant. This does not include a cost for additional supervision by a probation officer unless a new offense is anticipated to result in enough additional offenders to require additional probation officers.

expenses cost of $57,748 in FY 26 and $55,248 in FY 27, along with associated fringe benefit costs of $22,491 per year.

Section 3 also creates a civil penalty of $500,000 for violations resulting in a potential revenue gain to the state to the extent that violations occur.

**Sections 4 – 5** result in potential savings annually beginning in FY 26 to UConn Health Center, the Judicial Department, and the Departments of Mental Health and Addiction Services, Children and Families (DCF), Developmental Services and Public Health (which the bill terms "drug purchasing agencies"). Section 4 requires UConn Health to negotiate bulk prescription drug purchases on behalf of such agencies. Section 5 additionally allows such agencies to join interstate prescription drug purchasing compacts.

To the extent that bulk prescription drug purchasing results in lower prescription drug costs to drug purchasing agencies, there is a savings that will vary based on the amount of drugs purchased, and the change in per unit costs.

It should be noted that DCF does not operate a stand-alone pharmacy. Rather, the agency obtains medicines utilized at the Solnit Children's Center through a state contract that includes pharmacist services. Under this contract a combined cost of approximately $682,600 was incurred in FY 24 for medications, pharmacy services and distribution. A need for DCF to reestablish pharmacist services may result from the bill, should it be deemed that a new drug procurement system will be cost beneficial for the agency. This would require either retention of direct outside professional services or the creation of an in-house pharmacy. As discussed above, associated costs would be mitigated to the extent that savings are achieved through lower prescription drug prices, as well as from ending current contractual obligations.

Development of an in-house pharmacy would require DCF to hire at a minimum 1.5 FTE Pharmacists, at an annualized salary of $140,000

combined. Additional minimal salary costs would be incurred for 24/7 on-call coverage. Other expenses, which could be significant in magnitude, would be associated with installation of an automated medication dispensing and inventory management system, disposal of expired medicines, and enhanced security around drug storage. Annualized fringe benefits costs of $57,000 would be incurred by the Office of the State Comptroller.

**Section 6** establishes a Prescription Drug Affordability Council to advise the UConn Health Center on bulk prescription drug purchasing efforts and provide annual reports. This has no fiscal impact, as it is anticipated the council can complete its duties with existing resources.

**Section 7** results in a cost to the Department of Social Services (DSS) associated with requiring nursing homes to spend at least 80% of payment sources, including Medicaid and Medicare, on direct care. DSS will incur costs to reflect an additional associate accounts examiner (annual salary of $90,300 with associated fringe of approximately $36,800) to meet the requirements of the bill. To the extent DSS requires system modifications, the agency could experience additional costs.

Beginning in FY 28, DSS may incur savings related to lower Medicaid rates paid to any nursing homes not meeting the provisions of the bill. For context, the state share of Medicaid payments to nursing homes is approximately $700 million annually.

**Section 8** results in a cost to the Department of Social Services (DSS) associated with expanding coverage of emergency Medicaid services and requiring DSS to establish an administrative system for individuals to apply in advance for emergency Medicaid coverage by 7/1/26.

DSS will incur administrative costs of at least $250,000 in FY 26 to establish a registration system for individuals with qualifying emergency medical conditions that can be treated in outpatient settings rather than in hospital emergency departments. These costs are anticipated to be funded under Other Expenses and eligible for federal reimbursement, resulting in a federal grants revenue gain of at least

$125,000.

The fiscal impact of expanding the definition of emergency medical condition cannot be determined at this time. For context, the state currently spends approximately $27.5 million on emergency Medicaid services (representing a 50% share of total expenditures), which are generally emergent in nature and include outpatient dialysis for individuals with end-stage renal disease. Emergency Medicaid coverage is available to all individuals, regardless of immigration status, who meet Medicaid income and asset limits.

**Section 9** results in a cost to the Department of Social Services (DSS) of approximately $42 million in FY 26 and $150 million in FY 27 associated with expanding eligibility for HUSKY C. The bill increases the asset limit each year until eliminating the threshold on 7/1/29. Currently, the asset limit for HUSKY C is $1,600 for an individual and $2,400 for a married couple. The bill increases the asset limit to $10,000 for an individual and $15,000 for a couple effective 7/1/25, and to $25,000 and $40,000, respectively, effective 7/1/26. Estimates are based on coverage of similar members in other states and used as a proxy for estimating the potential increase in coverage for Connecticut. For context, this assumes an average cost of approximately $570 per member per month. This also assumes costs of approximately $1.2 million in FY 26 and $200,000 in FY 27 to support system change and maintenance costs, which result in a federal grants revenue gain of at least $600,000 in FY 26 and $100,000 in FY 27.

**Sections 10 – 11** result in a potential revenue gain to UConn Health Center annually beginning in FY 26. The sections prohibit insurance companies from putting time limits on covered anesthesia for specific procedures. To the extent such time limits are used currently, there is a revenue gain that would vary based on the procedures, and the reimbursement rates paid by insurers.

Sections 10-11 prohibit health insurance policies from placing time limits on general anesthesia coverage which does not result in a fiscal impact to the state or municipalities because carriers do not currently

impose these restrictions.

**Section 12** sets stop loss requirements for self-funded employee health benefit plans and does not result in a fiscal impact to the state because the state employee health plan meets the requirements outlined in the bill. Municipalities with self-funded employee health benefit plans face an indeterminate fiscal impact dependent on their current stop-loss policy or current coverage levels and how the outlined requirements impact premiums.

**Sections 13 – 15** make changes to DSS policies regarding Medicaid coverage for glucagon-like peptide (GLP-1) prescription drugs approved by the federal Food and Drug Administration (FDA) to treat obesity or diabetes. Under current practice, DSS covers weight loss drugs for Medicaid members with type 2 diabetes and Wegovy when prescribed to reduce the risk of a major adverse cardiac event.

Section 15 specifies that DSS cover weight loss drugs and requires such coverage to continue for beneficiaries, with physician approval, if their body mass index (BMI) drops below 35. State Medicaid costs for drugs used solely for the purpose of weight loss is anticipated to cost at least $55 million in FY 26 and $35 million in FY 27. As this reflects costs for members with a BMI of 35 and above, the actual costs will be higher after considering members whose BMI drops below that level and remain eligible.

Section 13 requires DSS to petition the federal Department of Health and Human Services to authorize generic, lower cost forms of GLP-1 prescription drugs to treat obesity or diabetes. If approved, the bill requires DSS to contract for such generic GLP-1 drugs to support HUSKY Health members. DSS will experience a savings to the extent a generic form of drugs otherwise utilized for those purposes are approved.

Section 14, which establishes an advisory committee to study ways to maximize access to cost-effective, FDA approved prescription drugs for the treatment of obesity and make recommendations, has no fiscal

impact.

**Sections 17-18** require DCP to regulate the 340b marketplace resulting in a cost to the state. DCP does not currently regulate this marketplace or have the expertise to do so and will have to hire two employees to meet the requirements of the bill. DCP will need to hire one drug control agent and one staff attorney for a salary and other expenses cost of $215,804 in FY 26 and $210,804 in FY 27, along with associated fringe benefit costs of $82,562 per year.

Section 18 also creates a civil penalty of $50,000 for every violation resulting in a potential revenue gain to the state to the extent that violations occur.

Sections 17 – 18 results in a potential savings to UConn Health Center annually beginning in FY 26. The sections restrict the ability of prescription drug manufacturers to limit the purchasing of 340B drugs by covered entities, which includes UConn Health. Any savings will vary based on any increase in the purchase of 340B drugs that occurs as a result of the bill. In FY 22, UConn Health saved $13 million via the purchase of 340B drugs.

**Sections 20-22** result in a potential cost to fully insured municipalities that currently impose cost sharing on insulin products to the extent cost sharing is imposed. Additional costs to municipalities can be incurred if they do not offer insulin products at the lowest wholesale acquisition cost. There is no fiscal impact to the state to impose these provisions as insulin products are currently covered under the state employee health plan with no cost sharing.

**Sections 26-35** create a Canadian Prescription Drug Importation Program (CPDIP) resulting in costs to the DCP and the Office of the State Comptroller (OSC). The bill requires DCP to hire a consultant to study the feasibility of establishing a CPDIP resulting in a cost of $100,000 in FY 26.

If the consultant reports that it's feasible to establish the CPDIP and

the program is approved by the federal Food and Drug Administration there is a cost to DCP and OSC. To run the program, DCP will need to hire two drug control agents and one staff attorney beginning in the last three months of FY 27, for a partial year salary and other expenses costs of $84,010 along with associated fringe benefit costs of $31,147 in FY 27.

**Section 36** creates an emergency preparedness and mitigation strategies for prescription drug shortages task force resulting in no fiscal impact to the state because the task force has the expertise to meet the requirements of the bill.

**Section 37** expands the Strategic Supply Chain Initiative program, which is funded by General Obligation (GO) bond funds, to include efforts to prevent or mitigate prescription drug shortages.

Future General Fund debt service costs may be incurred sooner under the bill to the degree that it causes authorized GO bond funds to be expended more rapidly than they otherwise would have been.

As of March 1, 2025, there is $25 million in previously allocated bond funds from Manufacturing Assistance Act program that have been set aside by the Department of Economic and Community Development to fund the Strategic Supply Chain Initiative program.

The bill does not change GO bond authorizations relevant to the program.

**Section 38** requires the Department of Public Health (DPH) to convene a Vaccines and Related Biological Products Advisory Committee to coordinate seasonal vaccine production and annually issue a report to the legislature.

DPH will incur costs of $134,700 in FY 26 and $130,750 in FY 27 (and annually thereafter), with an estimated cost to the Office of the State Comptroller for associated fringe benefits of $53,100 in both FY 26 and FY 27 (and annually thereafter). The Department does not currently have the staff necessary to support this advisory committee and would

need to hire additional personnel to meet the bill's requirements.[4]

The costs to DPH reflect the need for one new full-time Epidemiologist 3 to administer the Advisory Committee, at an annualized salary of $87,000 (plus $35,400 annualized fringe benefits). Additionally, a half-time (0.5 FTE) Epidemiologist 3 will be responsible for gathering, reviewing, analyzing, and preparing the requisite information needed by the Committee to address the proposed legislation, at an annualized salary of $43,500 (plus $17,700 annualized fringe benefits). Further costs associated with these positions are: (1) a one-time equipment cost of $3,950 in FY 26 for a laptop and related hardware; and (2) an ongoing cost of $250 in both FY 26 and FY 27 for general office supplies (which continues with inflation into the out years).

The bill also makes various other prescription drug related changes resulting in no fiscal impact to the state.

### *The Out Years*

The full-year potential costs to run the CPDIP (see sections 26-35 above) will begin in FY 28. To run the program there is a potential annual cost to DCP of $313,538 for salaries and other expenses, along with an associated fringe benefit potential cost of $124,588.

The annualized ongoing fiscal impact identified above would continue into the future subject to if the CPDIP is implemented, to Medicaid coverage and associated utilization of GLP-1 prescription drugs, emergency Medicaid services, and qualifying individuals under HUSKY C, the number of violations, and inflation.

[4] It should be noted that current DPH Immunization Program staff are funded through either federal grants or the Insurance Fund. The activities required by the bill are outside the scope of allowable work for these funding sources.

**OLR Bill Analysis**

**sSB 11**

***AN ACT CONCERNING PRESCRIPTION DRUG ACCESS AND AFFORDABILITY.***

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Establishes a Canadian prescription drug importation program; requires the DCP commissioner, on behalf of the state, to seek federal approval to import prescription drugs from Canada for distribution in the state; establishes testing, safety, and quality requirements; drug standards and tracking; establishes requirements for participating suppliers and wholesalers, including documentation, records retention, administrative proceedings, and penalties for violations; and authorizes DCP emergency actions (e.g., recalls), regulations, and reporting

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Creates a task force to study prescription drug shortage preparedness and mitigation

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Requires DECD to incorporate prescription drug shortage prevention or mitigation into its Strategic Supply Chain Initiative

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Requires DPH to convene an advisory committee to coordinate seasonal vaccine production along with drug manufacturers

## SUMMARY

This bill includes several provisions on prescription drugs, including setting manufacturer and wholesaler price caps for certain drugs, requiring UConn Health to negotiate bulk prices for state agencies, restricting limits on 340B drugs, expanding required reporting, and establishing a Canadian Prescription Drug Importation program, a prescription drug affordability council, a prescription drug shortage task force, and a vaccine and related biological products advisory committee.

It also makes several changes in Medicaid laws, including on nursing home spending requirements, emergency Medicaid expansions, HUSKY C asset limits, and weight loss drugs and treatments.

And, it makes changes in insurance laws, including provisions addressing private insurance coverage of anesthesia, stop-loss insurance policies, reporting requirements, insulin coverage, and pharmacy benefit managers.

These provisions are described in the section-by-section analysis below.

EFFECTIVE DATE: Various; see below.

## §§ 1-3 — IDENTIFIED PRESCRIPTION DRUGS

*Caps the price for the sale of identified prescription drugs in the state; generally imposes a civil penalty on pharmaceutical manufacturers and wholesale distributors who violate the cap and requires the DRS commissioner to impose and collect it; and creates a process for penalty disputes*

The bill sets a (1) cap on the prices for which pharmaceutical manufacturers and wholesale distributors can sell an identified

prescription drug in the state and (2) civil penalty for violators, except for those that made less than $250,000 in total annual sales in the state for the calendar year for which the penalty is being imposed. It also creates a process by which an aggrieved person can request a hearing to dispute the penalty. An "identified prescription drug" is a (1) brand-name drug or biological product for which the patent has expired for at least 24 months, or (2) generic drug or interchangeable biological product.

EFFECTIVE DATE: July 1, 2025

### *Price Cap on Identified Prescription Drugs (§§ 1 & 2(a))*

***Increase Based on Consumer Price Index.*** Starting January 1, 2026, regardless of state statute, the bill prohibits pharmaceutical manufacturers and wholesale distributors from selling an identified prescription drug in the state for more than its reference price, adjusted for any increase in the consumer price index.

Under the bill a "pharmaceutical manufacturer" is a person that manufactures a prescription drug and sells it, directly or through another person, for distribution in the state.

A "wholesale distributor" is a person engaged in the wholesale distribution of prescription drugs. This includes a repacker, own-label distributor, private-label distributor, or independent wholesale drug trader.

A "reference price" is the drug or biological product's wholesale acquisition price. For brand-name drugs or biological products, the reference price is the wholesale acquisition cost on January 1, 2025, or the date the patent expires, whichever is later. For generic drugs or interchangeable biological products, the reference price is the wholesale acquisition cost on January 1, 2025, or the date the drug or product is first commercially marketed in the U.S., whichever is later.

***Drug Shortage.*** The bill makes one exception by allowing manufacturers and distributors to exceed this price, starting January 1,

2026, if the federal Health and Human Services secretary determines that there is a shortage of the drug in the United States and includes it on the drug shortage list.

### *Civil Penalty for Violating Price Cap (§ 2(b))*

The bill imposes a civil penalty on pharmaceutical manufacturers and wholesale distributors that violate the price cap provision above. The civil penalty must be imposed, calculated, and collected by the state on a calendar year basis by the Department or Revenue Services (DRS) commissioner.

***Penalty Calculation.*** The civil penalty amount for a calendar year must be equal to 80% of the difference between the revenue that the pharmaceutical manufacturer or wholesale distributor:

1. earned from all sales of the identified prescription drug in the state during the calendar year; and

2. would have earned from these sales if the manufacturer or distributor had not sold the drug at a price over the bill's price cap.

***Exception.*** The bill exempts from liability for the above civil penalty, pharmaceutical manufacturers or wholesale distributors of an identified prescription drug that made less than $250,000 in total annual sales in the state for the calendar year for which the civil penalty would otherwise be imposed.

### *Penalty Payment and Statement Filing (§ 2(c))*

For calendar years starting January 1, 2026, each pharmaceutical manufacturer or wholesale distributor that violates the identified prescription drug price cap during any calendar year must, by March 1 immediately following the end of the calendar year:

1. pay the DRS commissioner the civil penalty for that calendar year; and

2. file with the DRS commissioner a statement for that calendar

year.

The commissioner must prescribe the statement's form and manner and required information.

***Electronic Filing and Wire Transfer.*** The manufacturer and distributor must file the statement electronically and pay the penalty by electronic funds transfer in the same way as filing and paying tax returns, regardless of whether they would have otherwise been required to do so under the law.

If no statement is filed as required above, the bill allows the DRS commissioner to make the statement at any time according to the best obtainable information and the prescribed form.

### *Record Examination and Retention (§ 2(d) & (e))*

***DRS Commissioner's Examination.*** The commissioner may, as he deems necessary, examine the records of any pharmaceutical manufacturer or wholesale distributor subject to the civil penalty imposed for an identified prescription drug price cap violation described above.

***Billing Due to Failure to Pay.*** After the examination, if the DRS commissioner determines that the pharmaceutical manufacturer or wholesale distributor failed to pay the full amount of the civil penalty, he must bill the pharmaceutical manufacturer or wholesale distributor for the full amount of the civil penalty.

***Records Retention.*** Under the bill, to provide or secure information pertinent to the civil penalty enforcement and collection, the DRS commissioner may require each pharmaceutical manufacturer or wholesale distributor subject to penalty to (1) keep records as the commissioner may prescribe and (2) produce books, papers, documents, and other data.

***Investigation.*** To verify the accuracy of any statement made or, to determine the amount of the civil penalty due if a statement was not

made, the DRS commissioner or his authorized representative may (1) examine the books, papers, records, and equipment of anyone subject to the identified prescription drug price cap provisions and (2) investigate the character of their business.

### *Aggrieved Company's Request for a Hearing (§ 2(f))*

***Hearing Application.*** Any pharmaceutical manufacturer or wholesale distributor that is subject to the civil penalty and aggrieved by the DRS commissioner's actions above (i.e. making a statement, billing, records examination, and investigation) may apply to the commissioner for a hearing. This must be done in writing within 60 days after the notice of the action is delivered or mailed to the manufacturer or distributor.

The aggrieved pharmaceutical manufacturer or wholesale distributor must state in the application (1) why the hearing should be granted and (2) if they believe they are not liable for the civil penalty or the full amount of the civil penalty, the (a) grounds for the belief and (b) amount by which they believe the civil penalty should be reduced.

***Hearing Denied or Granted.*** The DRS commissioner must promptly consider each application and notify the pharmaceutical manufacturer or wholesale distributor (1) immediately of a hearing denial or (2) of the date, time, and place for a hearing that is granted.

***DRS Commissioner's Orders.*** After the hearing, the commissioner may make orders as appears just and lawful to him and must give a copy to the pharmaceutical manufacturer or wholesale distributor.

***Hearing on the DRS Commissioner's Initiative.*** By notice and in writing, the commissioner may order a hearing on his own initiative and require a pharmaceutical manufacturer or wholesale distributor, or any other person the commissioner believes has relevant information, to appear before him, or his authorized agent, with any specified books of account, papers, or other documents for examination under oath.

### *Aggrieved Company's Appeal to Superior Court (§ 2(g))*

***Time Period to Appeal.*** Within 30 days after the aggrieved pharmaceutical manufacturer or wholesale distributor is served notice of the DRS commissioner's order, decision, determination, or disallowance, the manufacturer or distributor may appeal to the Superior Court for the New Britain judicial district.

***Accompanying Citation.*** The appeal must be accompanied by a citation to the DRS commissioner to appear before the court. The citation must be signed by the same authority and the appeal must be returnable at the same time and served and returned in the same way as required for a summons in a civil action.

***Bond or Recognizance With Surety.*** The authority issuing the citation must take from the appellant a bond or recognizance to the state, with surety, to prosecute the appeal to effect and to comply with the court's orders and decrees.

***Equitable Relief.*** Unless there is a reason otherwise, the appeals must be preferred cases and heard at the first session by the court or by a committee it appoints. The court may (1) grant equitable relief, and (2) if the civil penalty was paid before the relief was granted, order the state treasurer to pay the amount of the relief.

***Costs Taxed.*** If the appeal was made without probable cause, the court may tax double or triple costs, as appropriate. For appeals that are denied, costs may be taxed against the pharmaceutical manufacturer or wholesale distributor, but not against the state, at the court's discretion.

### *DRS Commissioner's Authority (§ 2(h))*

***Administer Oaths.*** The commissioner may administer oaths and take testimony under oath for any inquiry or investigation. The commissioner's agent duly authorized to conduct any inquiry, investigation, or hearing under the provisions above also has these powers.

***Subpoena Witnesses and Require Record Production.*** At any hearing the commissioner ordered, he may subpoena witnesses and

require the production of books, papers, and documents relevant to the inquiry or investigation. The commissioner's agent authorized to conduct the hearing and having authority by law to issue the process also has these powers.

A witness under any subpoena authorized to be issued under these provisions must not be excused from testifying or from producing books, papers, or documentary evidence on the ground that the testimony or the production would tend to incriminate the witness, but the books, papers, or documentary evidence produced must not be used in any criminal proceeding against the witness.

***Commitment to Community Correctional Center.*** If anyone disobeys the process or appears but refuses to answer the commissioner's or his agent's questions, the commissioner or the agent may apply to the Superior Court of the judicial district where the pharmaceutical manufacturer or wholesale distributor resides or where the business was conducted, or to any judge of the court if it is not in session, stating the disobedience to process or refusal to answer.

The court or judge must cite the person to appear to answer the question or produce the books, papers, or other documentary evidence and, if they refuse to do so, must commit the person to a community correctional center until they testify, but not for more than 60 days.

Regardless of the person serving the term of commitment, the DRS commissioner may continue the inquiry and examination as if the witness had not previously been called to testify.

***Fees and Compensation.*** Officers who serve subpoenas issued by the DRS commissioner or under his authority and witnesses attending hearings conducted by the commissioner under this provision must receive fees and compensation at the same rates as officers and witnesses in the state courts. This must be paid on vouchers of the DRS commissioner on order of the state comptroller from the proper appropriation for the administration of this provision.

### *State Collection and Attorney General's Lien Foreclosure (§ 2(i))*

***State Collection Agency Process.*** The amount of any unpaid civil penalty under the bill's price cap violations-related provisions may be collected using the process under existing law used by the state collection agency (i.e. the state treasurer; DRS commissioner; any other state official, board, or commission authorized to collect taxes payable to the state; and their duly authorized agents). Under the bill, the warrant issued under the collection process must be signed by the DRS commissioner or his authorized agent.

***Lien on Real Property.*** The amount of the civil penalty must be a lien on the pharmaceutical manufacturer's or wholesale distributor's real property from the last day of the month next preceding the civil penalty's due date until it is paid.

The DRS commissioner may record the lien in the records of the town in which the real property is located, but the lien is not enforceable against a bona fide purchaser or qualified encumbrancer of the real property.

***Certificate of Discharge.*** When the civil penalty for which a lien was recorded is satisfied, the DRS commissioner must, upon request of any interested party, issue a certificate discharging the lien. The discharge certificate must be recorded in the same office in which the lien was recorded.

***Foreclosure of the Lien.*** Any action for the foreclosure of the lien must be brought by the attorney general in the name of the state in the Superior Court for the judicial district in which the real property subject to the lien is located. If the real property is in two or more judicial districts, the action must be brought in the Superior Court for any one of the judicial districts.

The court may limit the time for redemption or order the sale of the real property or make any other decree as it judges equitable.

All civil penalties imposed under this provision can generally be

applied as a reduction against any amount payable by the state to the person, as under existing law related to penalties due from taxpayers.

### *Officer's and Employee's Liability (§ 2(j))*

***Willful Failure to Perform.*** An officer or employee of a pharmaceutical manufacturer or wholesale distributor, who (1) owes a duty, on the manufacturer's or distributor's behalf, to pay the civil penalty, file the required statement with the commissioner, keep records, or supply information to the commissioner and (2) willfully fails to do so must, in addition to any other penalty provided by law, be fined up to $1,000, imprisoned up to one year, or both.

Regardless of existing limitations of prosecution for certain violations or offenses, the bill sets a three-year statute of limitations for prosecuting officers or employees for violations of these provisions committed on or after January 1, 2026.

***Willful Delivery or Disclosure of Fraudulent or False Material.*** Any officer or employee of a pharmaceutical manufacturer or wholesale distributor who owes a duty, on the manufacturer's or distributor's behalf, to deliver or disclose to the commissioner, or his authorized agent, any list, statement, return, account statement, or other document and willfully delivers or discloses one the officer or employee knows is fraudulent or false in any material matter is guilty of a class D felony, in addition to any other penalty provided by law. (A class D felony is punishable by a fine up to $5,000, up to five years in prison, or both.)

Under the bill, an officer or employee may not be charged with an offense under both provisions above in relation to the same civil penalty but may be charged and prosecuted for both offenses based on the same information.

### *Waiver and Tax Credit Prohibited (§ 2(k))*

The civil penalty imposed under the bill for violating the identified prescription drug price cap:

1. is excluded from Medicaid provider tax calculations,

2. cannot be waived by the Penalty Review Committee under existing law or any other applicable law, and

3. cannot be reduced by applying a tax credit.

### *List of Violators and Implementing Regulations (§ 2(l) & (m))*

Starting by July 1, 2027, the bill requires the DRS commissioner to (1) annually prepare a list of the pharmaceutical manufacturers or wholesale distributors that violated the identified prescription drug price cap-related provisions during the preceding calendar year and (2) make each annual list publicly available.

The bill authorizes the commissioner to adopt regulations to implement its provisions related to identified prescription drug pricing and sales.

### *Withdrawal of Identified Prescription Drug (§ 3)*

***Required Notice to OHS.*** If a pharmaceutical manufacturer or wholesale distributor intends to withdraw an identified prescription drug from sale in the state, it must send written notice to the Office of Health Strategy (OHS) disclosing that intention at least 180 days before the withdrawal.

***Withdrawal to Avoid Penalty Prohibited.*** The bill prohibits a pharmaceutical manufacturer or wholesale distributor of an identified prescription drug from withdrawing the identified prescription drug from sale in the state to avoid the bill's civil penalty.

***Penalty.*** Any pharmaceutical manufacturer or wholesale distributor that violates the withdrawal provisions above is liable to the state for a $500,000 civil penalty.

### *Background — Related Bill*

sSB 6870 (File 308), §§ 11-13, favorably reported by the Insurance and Real Estate Committee, has substantially similar provisions on the sale of identified prescription drugs by pharmaceutical manufacturers and wholesale distributors in the state, including establishing a price cap

and civil penalties for violating it.

## §§ 4 & 5 — STATE DRUG PURCHASING AGENCY PRICE NEGOTIATIONS

*Requires UConn Health to negotiate bulk prices for prescription drugs on behalf of the state's drug purchasing agencies in order to buy them at lower cost; requires drug purchasing agencies, when negotiating drug prices with manufacturers, to incorporate the maximum fair price negotiated by CMS; allows drug purchasing agencies to enter compacts with other states for these purposes*

The bill requires the UConn Health Center to negotiate bulk prices for prescription drugs on behalf of itself and other drug purchasing agencies, including the judicial branch and the departments of Children and Families (DCF), Developmental Services, Mental Health and Addiction Services, and Public Health (DPH). UConn Health must do so with the goal to buy these drugs at lower prices than if the agencies each purchased them. The UConn Health Executive Director or his designee must report by September 1, 2025, to the General Law, Human Services, and Public Health committees on any savings achieved through bulk purchasing.

The bill requires these drug purchasing agencies, when negotiating with drug manufacturers to supply drugs for state-subsidized health care programs, to incorporate by reference the maximum fair price negotiated by the federal Centers for Medicare and Medicaid Services (CMS) for certain drugs under the federal Inflation Reduction Act (see *Background — Maximum Fair Price*).

The bill allows these drug purchasing agencies, either when negotiating bulk prices or referencing CMS's maximum fair price, to enter into a compact with officials in other states to increase the state's purchasing power in negotiations.

It also requires these drug purchasing agencies to consider the Prescription Drug Affordability Council's recommendations (see § 6) in these negotiations.

EFFECTIVE DATE: July 1, 2025

### *Background — Maximum Fair Price*

Federal law requires the CMS secretary to negotiate with manufacturers on the maximum fair price of certain drugs covered under Medicare. The secretary must do so for 10 drugs starting in 2026, 15 more for each of the next two years, and 20 additional per year starting in 2028. For the first two years, this only applies to certain drugs under Medicare Part D; in the third year, it extends to Medicare Part B (42 U.S.C. § 1320f et seq.).

## § 6 — PRESCRIPTION DRUG AFFORDABILITY COUNCIL

*Creates a council to advise the UConn Health Executive Director and drug purchasing agencies on prescription drug negotiations*

The bill establishes a Prescription Drug Affordability Council to advise the UConn Health executive director and drug purchasing agencies on drug negotiations (see §§ 4 & 5).

EFFECTIVE DATE: Upon passage

### *Council Members, Administration, and Reporting Requirement*

The council includes eight members appointed by legislative leaders, as shown in the following table.

**Table: Council Appointed Members**

| *Appointing Authority* | *Appointee Qualifications* |
|---|---|
| House speaker | Hospital organization representative<br>Physician organization representative |
| Senate president pro tempore | Academic who has researched prescription drug affordability<br>Representative of organization representing the state's seniors |
| House majority leader | Representative of physicians who treat patients with rare diseases |
| Senate majority leader | Unspecified qualifications |
| House minority leader | Unspecified qualifications |
| Senate minority leader | Unspecified qualifications |

The council also includes the DCF, Consumer Protection (DCP), OHS, Insurance, and Social Services (DSS) commissioners or their designees.

Any of the legislative leaders' appointed members may be legislators.

Appointing authorities must make their initial appointments within 30 days after the bill's passage and fill any vacancy.

The House speaker and Senate president pro tempore must select the task force chairpersons from among its members. The chairpersons must schedule and hold the first meeting within 60 days after the bill's passage. The Human Services Committee's administrative staff must serve in that capacity for the council.

The bill requires the council, starting by January 1, 2026, to annually report its findings and recommendations to the OHS commissioner and the General Law, Human Services, and Public Health committees.

## § 7 — NURSING HOME SPENDING ON DIRECT CARE

*Generally requires nursing homes, starting in FY 26, to spend at least 80% of their funding on direct resident care provided by nursing personnel; starting in FY 28, allows DSS to decrease Medicaid rates for nursing homes that do not comply*

The bill requires the DSS commissioner, beginning with fiscal year 2026, to require nursing homes to spend at least 80% of their funding from Medicaid, Medicare, and all other payment sources on residents' direct care. However, it allows the commissioner to adjust this percentage for nursing homes with a capital improvement project or fair rent increase DSS approved. Beginning with fiscal year 2028, the commissioner may decrease Medicaid reimbursement for any nursing home that does not comply.

Under the bill, "direct care" means hands-on care nursing personnel provide to facility residents (e.g., help with feeding, bathing, toileting, dressing, lifting or moving residents, or administering medication). It also includes nursing personnel's salary and fringe benefits and the cost of supplies to provide hands-on care. Nursing personnel include advanced practice registered nurses, registered or practical nurses, and nurse's aides.

EFFECTIVE DATE: July 1, 2025

### *Background — Related Bills*

SB 805, favorably reported by the Human Services Committee, also

requires nursing homes to spend at least 80% of their funding on residents' direct care.

SB 1417, favorably reported by the Human Services Committee, establishes a nursing home workforce standards board to set standards for wages and other matters for nursing home employees.

sSB 1415, favorably reported by the Human Services Committee, requires nursing homes to increase the minimum hourly wage for certain employees to $22.50 by January 1, 2026, and $25.00 by January 1, 2027.

## § 8 — EMERGENCY MEDICAID EXPANSION

*Requires DSS to expand emergency Medicaid coverage for certain conditions and create a system allowing people to apply in advance for emergency coverage for treatment in outpatient settings for these conditions*

The bill requires the DSS commissioner to expand, in a way consistent with federal law, Medicaid coverage for treating emergency medical conditions (i.e. emergency Medicaid, see *Background — Emergency Medicaid Coverage*). Under the bill, an "emergency medical condition" is a medical condition, including emergency labor and delivery, with acute symptoms severe enough that it can be expected to result in the following without treatment:

1. placing the patient's health in serious jeopardy,
2. serious impairment to bodily functions, or
3. serious dysfunction of an organ or body part.

The bill lists several conditions that must qualify for emergency Medicaid coverage under the expansion.

The bill also requires the DSS commissioner, by July 1, 2026, to create an administrative system for people to apply in advance for emergency Medicaid coverage for outpatient treatment for emergency medical conditions. The commissioner must include (1) a link to the application and list of covered emergency medical conditions on the DSS website

and (2) information about advance applications for emergency Medicaid and a list of covered conditions in DSS forms and policy manuals.

EFFECTIVE DATE: July 1, 2025

### *Emergency Medical Conditions*

Under the bill, DSS's emergency Medicaid expansion must include coverage for the following conditions to the extent allowed by federal law:

1. high-risk pregnancy;
2. type 1 diabetes in people under age 21;
3. diabetic emergencies, including diabetic ketoacidosis;
4. renal failure requiring ongoing dialysis;
5. a skull, arm, neck, leg, spine, or pelvis fracture that occurred in the two-month period before an emergency Medicaid request;
6. hypertensive emergencies in people with symptoms of end organ damage and systolic blood pressure of at least 180 or diastolic blood pressure of at least 120;
7. unstable seizure disorder with at least five minutes of uncontrollable seizures or at least two discrete seizures where the person does not regain consciousness between them;
8. active cancer treatment;
9. ventilator dependency;
10. labor and delivery; and
11. acute inpatient or outpatient psychiatric treatment.

### *Background — Emergency Medicaid Coverage*

Under current state policy, emergency Medicaid coverage is

generally limited to treatment after the sudden onset of a medical emergency. It does not cover treatment for chronic conditions, even if the condition may be life threatening. Emergency Medicaid cannot be preapproved, and instead a bill for emergency treatment is submitted to DSS for review.

However, federal law gives states flexibility to define what treatments or conditions qualify for emergency Medicaid coverage within the parameters of the "emergency medical condition" definition above. For example, in 2021 DSS determined that ongoing dialysis for end stage renal disease qualifies for emergency Medicaid coverage because without dialysis, the condition will likely become a medical emergency.

Emergency Medicaid allows hospitals to receive federal Medicaid reimbursement for care that may otherwise be uncompensated. Any person, regardless of immigration status, can qualify for emergency Medicaid coverage if he or she meets Medicaid income and asset limits.

### *Background — Related Bill*

SB 806, favorably reported by the Human Services Committee, also requires DSS to expand Medicaid coverage for treating emergency medical conditions.

## § 9 — PHASEOUT OF HUSKY C ASSET LIMIT

*Requires DSS to increase and then eliminate the HUSKY C asset limit over a five-year period*

The bill requires the DSS commissioner to increase and then eliminate the HUSKY C asset limit over a five-year period, as shown in the table below. HUSKY C provides Medicaid coverage to people who are age 65 or older, blind, or living with a disability.

**Table: HUSKY C Asset Limit Changes Under the Bill**

| *Time Period* | *Single Person* | *Married Couple* |
|---|---|---|
| Current law | $1,600 | $2,400 |
| FY 26 | $10,000 | $15,000 |

| Time Period | Single Person | Married Couple |
|---|---|---|
| FY 27 | $25,000 | $40,000 |
| FY 28 | $75,000 | $100,000 |
| FY 29 | $100,000 | $150,000 |
| FY 30 | No Limit | No Limit |

The bill also requires the commissioner to allow a person to spend down income that exceeds HUSKY C income limits on incurred medical bills in accordance with federal regulations on Medicaid spend-downs, so long as the person otherwise qualifies for HUSKY C, generally conforming to current practice.

Lastly, the bill requires the commissioner, starting by July 1, 2026, to report annually to the Appropriations and Human Services committees on (1) the number of people eligible for HUSKY C for the prior fiscal year and (2) any increased costs incurred by the state that are attributable to the bill's changes in asset limits.

EFFECTIVE DATE: July 1, 2025

### *Background — Related Bills*

SB 807, favorably reported by the Human Services Committee, also requires DSS to eliminate the asset limit for HUSKY C over a five-year period.

SB 981, favorably reported by the Human Services Committee, requires DSS to disregard certain Social Security income for disabled adult children when determining income eligibility for HUSKY C.

sHB 6911 (File 110), favorably reported by the Aging Committee, requires DSS, starting July 1, 2025, to increase HUSKY C asset limits by at least the same percentage increase as the national consumer price index.

## §§ 10 & 11 — REIMBURSEMENT FOR GENERAL ANESTHESIA

*Prohibits health insurance policies from imposing (1) arbitrary time limits on reimbursement for medically necessary general anesthesia or (2) unilateral arbitrary limitations on reimbursement for medically necessary ancillary services*

The bill prohibits certain individual and group health insurance policies that cover general anesthesia from (1) imposing arbitrary time limits on reimbursement for general anesthesia during a medically necessary procedure or (2) denying, reducing, terminating, or not providing reimbursement for general anesthesia solely because its duration exceeded the insurer's predetermined time limit for the care. It also prohibits the policies from imposing unilateral arbitrary limitations on reimbursement for medically necessary ancillary services.

The bill requires the attending board-certified anesthesiologist to determine the medical necessity of general anesthesia during a medical procedure.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2026, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2026

### *Background — Related Bill*

sSB 10, §§ 17 & 18, favorably reported by the Insurance and Real Estate Committee, includes the same requirements for medically necessary general anesthesia and ancillary services reimbursements as this bill.

## § 12 — STOP-LOSS INSURANCE POLICIES WITH SELF-FUNDED EMPLOYEE HEALTH PLANS

*Requires any stop-loss insurance policies used in conjunction with self-funded employee health benefit plans to either (1) provide specified benefits or (2) have a set minimum individual and aggregate attachment point*

Generally, employers use stop-loss insurance policies under self-funded plans to protect against catastrophic losses. The threshold for stop-loss coverage is generally referred to as the "attachment point."

The bill requires any stop-loss insurance policy used along with a self-funded employee health benefit plan to either:

1. provide essential health benefits required under the federal Affordable Care Act and the group state-mandated coverage requirements under state health insurance laws or

2. have a minimum individual attachment point of at least $75,000 and an aggregate attachment point of at least $250,000.

(It is unclear whether the first provision above could be enforced, because federal law (ERISA) preempts the state from regulating a self-insured plan's benefits.)

Current Insurance Department guidelines (Bulletin HC-126) prohibit a stop-loss policy from:

1. having an annual individual attachment point less than $20,000;

2. for a small employer (i.e. 50 or fewer group members), having an annual aggregate attachment point less than the greater of $20,000, $4,000 times the number of covered individuals, or 120% of expected claims;

3. for a large employer, having an annual aggregate attachment point less than 110% of expected claims; or

4. providing direct coverage for an individual's health care or medical expenses.

EFFECTIVE DATE: January 1, 2026

## § 13 — GENERIC GLP-1 DRUGS FOR WEIGHT LOSS

*Requires DSS to take certain steps to increase access to generic, lower cost forms of GLP-1 drugs*

The bill requires DSS, within 30 days after the bill's passage, to petition the federal Department of Health and Human Services (HSS) secretary to authorize generic, lower cost forms of glucagon-like peptide GLP-1 drugs (e.g., Ozempic) that are FDA approved to treat obesity or diabetes. (Currently, there are two generic versions of GLP-1 drugs approved to treat diabetes, but none specifically approved to treat obesity.)

Under the bill, if HHS approves the petition, the DSS commissioner must contract with a manufacturer to supply the state with a generic form of these drugs for HUSKY Health members. The commissioner may enter into a consortium with other states in such a contract.

The bill requires the commissioner to develop a strategic plan to maximize access to these drugs and minimize their cost. By December 31, 2025, she must report on the plan to the Human Services Committee and the Obesity Drug Advisory Committee created under the bill (see below).

EFFECTIVE DATE: Upon passage

## § 14 — OBESITY DRUG ADVISORY COMMITTEE

*Creates an advisory committee to study and make recommendations on ways to maximize access to cost-effective, FDA-approved prescription drugs to treat obesity*

The bill establishes an advisory committee to study ways to maximize access to cost-effective, FDA-approved prescription drugs to treat obesity and make recommendations to DSS.

The committee includes six members, as shown in the following table.

**Table: Obesity Drug Advisory Committee Members**

| *Appointing Authority* | *Appointee Qualifications* |
|---|---|
| Council on Medical Assistance Program Oversight chairperson | Two patient advocates |
| DSS commissioner | Two Medicaid-enrolled pharmacists |
| Human Services | Two medical professionals, including at least one doctor |

| Appointing Authority | Appointee Qualifications |
|---|---|
| Committee chairpersons | certified by the American Board of Obesity Medicine |

The bill requires the committee to meet within 30 days after the bill's passage, choose a chairperson, and meet at least bimonthly.

Under the bill, the committee must review DSS's strategic plan on generic GLP-1 drugs (see § 13) and make recommendations to DSS on implementing the plan and the results of its study by January 31, 2026. The committee ends when it submits its recommendations to DSS or on January 31, 2026, whichever is later.

EFFECTIVE DATE: Upon passage

## § 15 — MEDICAID COVERAGE OF WEIGHT LOSS DRUGS

*Expands Medicaid coverage for weight loss drugs by requiring DSS to cover glucagon-like peptide 1 (GLP-1) prescription drugs to treat obesity under certain circumstances*

Current law requires DSS to provide medical assistance for medical services for Medicaid and HUSKY B beneficiaries with a body mass index over 35, so long as the beneficiaries otherwise meet conditions set by CMS. By law, medical services include FDA-approved prescription drugs to treat obesity on an outpatient basis and nutritional counseling provided by a registered dietitian.

The bill expands this coverage by (1) removing the requirement that beneficiaries meet CMS conditions and (2) specifying that medical services include GLP-1 prescription drugs approved by the FDA for weight loss or commonly used for weight loss, sleep apnea, or to reduce risks of cardiovascular disease. The bill requires the DSS commissioner to continue providing Medicaid coverage for beneficiaries treated with GLP-1 prescription drugs in cases where their BMI drops below 35 if a physician certifies that their BMI would increase above 35 if GLP-1 drugs were discontinued. Existing law and the bill authorize DSS to amend the Medicaid state plan or the Children's Health Insurance Program state plan if needed to implement this coverage.

EFFECTIVE DATE: July 1, 2025

### *Background — Related Bills*

sSB 1474, favorably reported by the Human Services Committee, also expands Medicaid coverage for weight loss drugs.

## § 16 — HEALTH CARRIER REBATE ANNUAL REPORTING

*Expands the contents of the insurance commissioner's annual report on health carrier rebates to include certain information on how rebates affected cost sharing*

Existing law requires the insurance commissioner to annually report on health carrier rebate practices for the prior year and publish the report on the department's website. The bill expands the required contents of this report to include the (1) percentage of rebate dollars health carriers used to reduce cost-sharing requirements and (2) an evaluation of rebate practices to reduce cost-sharing for health care plans delivered, issued, renewed, amended, or continued.

Under existing law, the report must include (1) an explanation of how carriers accounted for rebates when calculating premiums, (2) a statement disclosing whether and how carriers made rebates available to insureds at the point of purchase, (3) any other way carriers applied rebates, and (4) any other information the commissioner deems relevant.

EFFECTIVE DATE: October 1, 2025

### *Background — Related Bill*

sHB 7192, § 3, favorably reported by the Human Services Committee, has identical provisions on rebate annual reporting.

## §§ 17 & 18 — 340B PROGRAM

*Generally prohibits drug manufacturers from (1) limiting access to 340B drugs for pharmacies contracting with covered entities and (2) requiring pharmacies or covered entities to submit claims or utilization data as a condition for receiving 340B drugs; establishes a hearing process and penalties for violators*

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 at discounted prices to health care organizations that care for uninsured and low-income patients. Pharmacies may contract with 340B-participating

healthcare organizations to also purchase reduced-price outpatient drugs.

The bill prohibits drug manufacturers (including biologics manufacturers), and their agents or affiliates, from directly or indirectly taking any of the following actions:

1. denying or limiting access to 340B drugs for a pharmacy contracting or otherwise working with a covered entity (see below) to obtain them on the entity's behalf, unless the pharmacy's receipt of a drug is federally prohibited, or

2. requiring a covered entity, or pharmacy contracted with a covered entity, to submit claims or utilization data as a condition for acquiring a 340B drug, unless the claims or data sharing is federally required.

For these restrictions, "covered entities" are the UConn Health Center, federally qualified health centers, family planning clinics, and Ryan White clinics (i.e. clinics that receive specified HIV and AIDS-related federal funding). (Federal law allows other organizations to participate in the 340B program, such as hospitals that serve a disproportionate number of low-income patients.)

Also, under these provisions, 340B drugs are those that a covered entity (1) purchases under the program and that are subject to the program's pricing requirements or (2) would purchase except for the prohibited conduct.

The bill subjects violators to civil penalties (see below). It also requires the DCP commissioner to adopt implementing regulations.

The bill specifies that its 340B provisions must not be applied in a way that conflicts with, or is less restrictive than, applicable state and federal laws (including the federal law on drug risk evaluation and mitigation strategies (REMSs); see *Background — REMS*).

EFFECTIVE DATE: Upon passage

### *Violations*

Beginning July 1, 2025, the bill subjects manufacturers (or their agents or affiliates) to a civil penalty of up to $50,000 per violation if the DCP commissioner has a reasonable belief, based on received information, that they have violated these provisions or regulations.

The commissioner must issue the violation notice by first-class mail or personal service, and it must include:

1. a reference to the law or regulation that has allegedly been violated;

2. a short and plain language statement of the matter;

3. a description of the activity to cease;

4. the penalty amount that may be imposed; and

5. an explanation of the right to request, in writing to DCP, a hearing within 10 business days after receiving the notice.

Under the bill, DCP must hold requested hearings as contested case hearings under the Uniform Administrative Procedure Act (UAPA). If after a hearing, DCP finds, by a preponderance of the evidence, that a violation has occurred or that the entity has violated any DCP order, the department must issue a final cease and desist order in addition to any civil penalty imposed.

If the manufacturer, agent, or affiliate does not timely request a hearing, DCP must issue a cease and desist order or impose a civil penalty.

### *Background — REMS*

Federal law authorizes the FDA to require a drug safety program (called "REMS") for certain prescription medications with serious safety concerns to ensure that the medications are used safely and the risks of serious or life-threatening side effects are minimized for patients, pharmacies, and providers (21 U.S.C. § 355-1).

## § 19 — "PAY TO DELAY" REPORTING

*Requires pharmaceutical manufacturers to annually report to DCP any agreements with a competitor to delay the launch of generic drugs; allows DCP to set penalties for the failure to report*

The bill requires pharmaceutical manufacturers doing business in the state to annually report to DCP any "pay to delay" agreements with a competitor and the prescription drugs included in the agreement. Under the bill, these are agreements between a pharmaceutical manufacturer and a competitor to delay launching a generic drug based on an expiring or expired patent for one of the manufacturer's drugs. Manufacturers must report in a form and manner DCP sets.

The bill also requires DCP to adopt implementing regulations. The department also may establish penalties and an administrative hearing process under the UAPA for manufacturers that violate the reporting requirement.

EFFECTIVE DATE: July 1, 2025

## §§ 20-22 — INSULIN PRODUCT INSURANCE COVERAGE

*Requires state entities and health benefit plans to cover certain insulin products at the lowest wholesale acquisition cost in a preferred tier with no copayment or out-of-pocket cost; allows plans to cover and offer more than one insulin product*

The bill requires state entities and health benefit plans to make available to beneficiaries an eligible insulin product at the lowest wholesale acquisition cost in a preferred tier with no copayment or other out-of-pocket cost. This applies unless a collective bargaining agreement requires otherwise for the state employee plan. An "eligible insulin product" is an insulin product, including pens or vials, for which at least two licenses have been issued and that continues to be marketed.

Under current law, commercial health benefit plans generally must cap the out-of-pocket cost of insulin at $25 per 30-day supply.

The bill also allows state entities and health benefit plans to (1) cover more than one eligible insulin product in a preferred tier with no out-of-pocket costs and (2) offer, with no out-of-pocket costs, another eligible insulin product if it has a net cost lower than the lowest

wholesale acquisition cost. Under the bill, an insulin product's net cost takes into account rebates or discounts, excluding those required under state or federal law or those related to portfolio agreements for purchasing multiple insulin products or other drugs.

For commercial plans, the bill applies the above requirement to high deductible health plans (HDHP) to the maximum extent permitted by federal law. If the HDHP is used to establish a health savings or similar account, the bill applies to the maximum extent permitted by federal law that does not affect the account's tax preferred status.

Because of ERISA, state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2026

## § 23 — PHARMACY BENEFITS MANAGER FIDUCIARY DUTY AND HEALTH CARRIER CONTRACTS

*Provides that PBMs owe a fiduciary duty to health carriers or other health plan sponsors and generally prohibits carrier contracts from allowing or requiring a party to violate the carrier's fiduciary duty to insureds*

The bill provides that pharmacy benefits managers (PBMs) owe a fiduciary duty to any heath carriers (e.g., insurers) or other health benefit plan sponsors (in other words, have the legal duty to act in the carriers' or sponsors' interests). It also provides that PBMs have an obligation of good faith and fair dealing in performing their duties with all parties, including carriers or other plan sponsors they interact with in performing their management services.

Under the bill, a PBM must notify the carrier or other plan sponsor, in writing, if any of the PBM's activities, policies, or practices directly or indirectly present a conflict of interest with its duties under the bill.

The bill also prohibits any health carrier contracts entered into or amended after October 1, 2025, from allowing or requiring a party to violate the fiduciary duty that the carrier owes to the carrier's covered persons (i.e. insureds). This applies despite any contrary provisions in the state's insurance laws and to the maximum extent allowed by law.

Under the bill, a violation of any of these provisions is an unfair insurance practice (see *Background — Connecticut Unfair Insurance Practices Act*).

The bill allows the insurance commissioner to adopt implementing regulations.

EFFECTIVE DATE: October 1, 2025

### *Background — Connecticut Unfair Insurance Practices Act*

The law prohibits engaging in unfair or deceptive acts or practices in the business of insurance. It authorizes the insurance commissioner to conduct investigations and hearings, issue cease and desist orders, impose fines, revoke or suspend licenses, and order restitution for per se violations (i.e. violations specifically listed in statute). The law also allows the commissioner to ask the attorney general to seek injunctive relief in Superior Court if he believes someone is engaging in other unfair or deceptive acts not specifically defined in statute.

Fines may be up to (1) $5,000 per violation to a $50,000 maximum or (2) $25,000 per violation to a $250,000 maximum in any six-month period if the violation was knowingly committed. The law also imposes a fine of up to $50,000, in addition to or in place of a license suspension or revocation, for violating a cease and desist order (CGS §§ 38a-815 to -819).

### *Background — Related Bill*

sHB 7192, § 1, favorably reported by the Human Services Committee, contains the same provisions on PBMs' fiduciary duty and carrier contracts.

## § 24 — PHARMACY SERVICES CONTRACTS

*Prohibits certain provisions in pharmacy services contracts, such as those allowing a PBM to charge a health plan a contracted price that differs from what the PBM pays the pharmacy for the services*

The bill prohibits a pharmacy services contract between a pharmacist or pharmacy and health carrier or PBM from allowing the PBM to charge an in-state health benefit plan a contracted price for any

pharmacy services that differs from what the PBM pays the pharmacy (directly or indirectly) for these services (sometimes called a "spread pricing" arrangement).

It further prohibits these contracts from allowing the PBM to charge a health benefit plan, directly or indirectly, a fee that depends on any of the following:

1. a prescription drug's wholesale acquisition cost or another price metric for these drugs;

2. the amount of savings, rebates, or other fees charged, collected, or generated based on the PBM's business practices; or

3. the amount of charged premiums or cost-sharing requirements under the plan that the PBM collects from covered persons.

As under existing law for prohibited provisions in these contracts:

1. any contract provision that violates the bill is void and unenforceable, but a provision rendered invalid or unenforceable does not affect remaining provisions;

2. any general business practice that violates the bill's provisions is an unfair trade practice under the Connecticut Unfair Trade Practices Act (CUTPA, see *Background — Connecticut Unfair Trade Practices Act*); and

3. the insurance commissioner may enforce the bill's provisions and upon request, audit pharmacy services contracts for compliance.

EFFECTIVE DATE: January 1, 2026

### *Background — Connecticut Unfair Trade Practices Act*

By law, CUTPA prohibits businesses from engaging in unfair and deceptive acts or practices. It allows the DCP commissioner, under specified procedures, to issue regulations defining an unfair trade practice, investigate complaints, issue cease and desist orders, order

restitution in cases involving less than $10,000, impose civil penalties of up to $5,000, enter into consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and up to $25,000 for a restraining order violation.

### *Background — Related Bill*

sHB 7192, § 2, favorably reported by the Human Services Committee, has identical provisions on pharmacy services contracts.

## § 25 — HEALTH CARRIER PRICING AND PROFIT REPORTING REQUIREMENTS

*Requires the insurance commissioner to require carriers to annually report on pricing offered to, and profit generated between, the carrier and any PBM or mail-order pharmacy*

Under the bill, the insurance commissioner must require health carriers to annually report on pricing offered to, and profit generated between, the carrier and any PBM or mail-order pharmacy doing business in Connecticut. The commissioner must post a link on the department's website to these reports.

EFFECTIVE DATE: July 1, 2025

### *Background — Related Bill*

sHB 7192, § 4, favorably reported by the Human Services Committee, also requires this annual reporting on carrier pricing.

## §§ 26-35 — CANADIAN PRESCRIPTION DRUG IMPORTATION PROGRAM

*Establishes a Canadian prescription drug importation program; requires the DCP commissioner, on behalf of the state, to seek federal approval to import prescription drugs from Canada for distribution in the state; establishes testing, safety, and quality requirements; drug standards and tracking; establishes requirements for participating suppliers and wholesalers, including documentation, records retention, administrative proceedings, and penalties for violations; and authorizes DCP emergency actions (e.g., recalls), regulations, and reporting*

The bill establishes a Canadian prescription drug importation program under which the DCP commissioner, on behalf of the state,

would seek federal approval to import prescription drugs from Canada that have the highest potential for cost savings in the state. ("Prescription drug" is a legend drug approved by the federal Food and Drug Administration (FDA), or any successor agency, and prescribed by a health care provider to an individual in the state.)

EFFECTIVE DATE: October 1, 2027, except July 1, 2025, for the provisions that define the applicable terms and require the DCP feasibility study.

### *Feasibility Study and Report (§ 27)*

The bill requires the DCP commissioner to:

1. hire, within available resources, a consultant to study the feasibility of establishing a Canadian prescription drug importation program to reduce prescription drug costs in the state; and

2. by October 1, 2027, report the findings to the Appropriations, General Law, and Human Services committees and the Office of Policy and Management (OPM).

### *Food and Drug Administration Approval (§ 28)*

***Request for FDA Approval.*** If the DCP commissioner, in consultation with the OPM secretary, determines the program is feasible, the bill authorizes the commissioner to request program approval from the FDA.

At a minimum, the request to the FDA must do the following:

1. describe (a) the state's plans for operating the program and (b) any opportunities to coordinate with other states,

2. demonstrate that any prescription drug imported and distributed in this state under the program would (a) meet all applicable federal and state standards for safety and effectiveness and (b) comply with all federal tracing procedures, and

3. state the estimated program implementation costs.

The bill authorizes the DCP commissioner to spend resources before FDA approval to ensure efficient implementation, but it prohibits the commissioner from actually operating the program without FDA approval.

***FDA-Approval Received.*** If the FDA approves the request, the DCP commissioner must submit a notice disclosing it to the OPM secretary; Social Services and Health Strategy commissioners; and Appropriations, General Law, Human Services, and Public Health committees.

### *Prescription Drug Importation, Distribution, and Standard (§§ 26, 29 & 30)*

***Importation and Distribution.*** If a Canadian prescription drug importation program is established under the bill, participating wholesalers may, subject to the bill's provisions and under the program, import and distribute drugs in this state from a participating Canadian supplier to pharmacies, institutional pharmacies, and qualifying laboratories.

***Drug.*** For purposes of the Canadian prescription drug importation program, "drug" means an article that is:

1. recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, official National Formulary, or any of their supplements;

2. intended to diagnose, cure, mitigate, treat, or prevent disease in humans;

3. not food and intended to affect the structure or any function of the human body; and

4. not a device and intended for use as a component of any article specified in those listed above.

***Participating Wholesaler.*** A "participating wholesaler" in the program is designated by DCP to distribute prescription drugs in the manufacturer's original container, obtained from a participating Canadian supplier.

***Participating Canadian Supplier.*** A "participating Canadian supplier" in the program is a Canadian supplier that is exporting prescription drugs, in the manufacturer's original container, to a participating wholesaler for distribution in the state under the program.

***Canadian Supplier.*** A "Canadian supplier" is a manufacturer or wholesale drug distributor licensed or permitted under applicable Canadian law to manufacture or distribute prescription drugs.

An "institutional pharmacy" is the area within a care-giving, correctional, or juvenile training institution where drugs are stored and dispensed under the direct charge of a pharmacist. This area is commonly known as the pharmacy.

***Drug Standards.*** Under the program, participating wholesalers may import and distribute prescription drugs in this state from a participating Canadian supplier under the program if doing so would not violate federal patent laws and the drug meets the FDA's drug safety, effectiveness, misbranding, and adulteration standards.

A drug cannot be imported under the program if it is:

1. considered a controlled substance under federal law;

2. a biological product (e.g., a virus, therapeutic serum, vaccine, blood, or blood component applied to prevent, treat, or cure a human disease or condition);

3. one that is infused, intravenously injected, or inhaled during surgery; or

4. a parenteral drug that the federal Health and Human Services secretary determines would pose a threat to the public health if

imported.

### *Track-and-Trace-Related Requirements (§§ 26 & 31)*

Under the program, the DCP commissioner must require participating Canadian suppliers and participating wholesalers to (1) comply with all applicable track-and-trace requirements and (2) make all track-and-trace records available within 48 hours after the commissioner requests them.

"Track-and-trace" is the product tracing process in the federal Drug Quality and Security Act for the components of the pharmaceutical distribution supply chain.

The DCP commissioner must prohibit the distribution, dispensing, or sale outside the state of any prescription drug imported under the program.

### *Safety and Quality Requirements (§§ 26 & 32(a))*

A participating wholesaler under the program must ensure the safety and quality of all drugs imported and distributed in the state under the program.

***Drug Requirements.*** The drugs must (1) be approved for marketing in the United States; (2) not be adulterated or misbranded; and (3) meet all labeling requirements (e.g., content, prominence of information, and designation of established names) under federal law.

***Laboratory Testing.*** Under the bill, "laboratory testing" is a quantitative and qualitative analysis of a drug consistent with the applicable provisions of the official United States Pharmacopoeia.

The bill requires a participating wholesaler to engage a qualifying laboratory (i.e. one in the United States approved by the FDA for purposes of the federal Food Drug and Cosmetic Act) to test for authenticity and degradation a (1) statistically valid sample size for each batch of each drug in the initial shipment and (2) statistically valid sample of the shipment.

The laboratory must do testing consistent with the federal Food, Drug and Cosmetic Act.

### *Laboratory Records Maintenance and Retention Requirements (§ 32(a) & (b))*

Under the program, a participating wholesaler must maintain:

1. qualifying laboratory records, including complete data derived from all tests necessary to ensure that each drug imported under the program complies with the bill's safety and quality requirements; and

2. documentation demonstrating that the required testing was done at a qualifying laboratory consistent with the federal Food, Drug and Cosmetic Act and all other applicable federal and state laws and regulations on qualifying laboratory qualifications.

After a qualifying laboratory submits information and documentation to the participating wholesaler, the wholesaler must keep them for at least three years from the submission date.

### *Participating Wholesaler Documentation Requirements (§ 32(c))*

A participating wholesaler must also maintain the following information for each drug the wholesaler imports and distributes in the state under the program:

1. the name and quantity of the drug's active ingredient and a description of the drug's dosage form,

2. the date the participating wholesaler received the drug and the price the wholesaler paid,

3. the quantity the participating wholesaler received and the drug's point of origin and destination,

4. a report on any drug that fails qualifying laboratory testing, and

5. any additional information and documentation that the commissioner deems necessary to protect public health.

The wholesaler must submit the above information and documentation to the commissioner, upon the commissioner's request.

### *Participating Supplier Documentation Requirements (§ 32(d))*

The DCP commissioner must require each participating Canadian supplier to maintain the following information and documentation for each drug the supplier exports into the state under the program:

1. the original source of the drug, including the manufacturer's name and manufacture date and location;

2. the shipping date and quantity;

3. the quantity of each lot of the drug originally received and the source of the lot;

4. the lot or control number and batch number the manufacturer assigned to the drug; and

5. any additional information and documentation that the DCP commissioner deems necessary to ensure public health protection.

The supplier must submit the above information and documentation to the commissioner, upon the commissioner's request.

### *Authorized Emergency Actions for Public Health or Welfare (§ 33)*

The bill authorizes the DCP commissioner to issue cease and desist, recall, embargo, or destruction orders to program participants when warranted and subject to administrative proceedings and penalties.

***Cease and Desist Order.*** If the DCP commissioner determines that public health, safety, or welfare requires emergency action, the commissioner may order a participating Canadian supplier, participating wholesaler, relabeler, repacker, and qualifying laboratory to cease and desist from actions specified in the order pending administrative proceedings. The cease and desist order must be in writing and signed by the commissioner and is effective upon delivery

to the respondent.

***Administrative Proceeding and Civil Penalty.*** After a cease and desist order is issued, an administrative proceeding, done according to the Uniform Administrative Procedures Act, must begin promptly. After a hearing, the commissioner may impose a civil penalty up to $10,000.

***Recall, Embargo, or Destruction.*** The commissioner may require the recall, embargo, or destruction of any drug that was imported and distributed under the program that has been identified as adulterated or misbranded. Any such action must be done according to DCP's process for food, drug, and cosmetic seizures and embargoes in existing law, which includes a hearing and possible civil penalty.

Generally, a drug is deemed adulterated under several circumstances. For example, if it consists of any filthy, putrid, or decomposed substance; or has been produced, prepared, packed, or held under insanitary conditions so that it may have been contaminated with filth or made injurious to health.

***Written Notice to Impacted Businesses.*** If a cease and desist, recall, embargo, or destruction order is issued, the person adversely impacted by the order must notify all other businesses participating in the program of the order. The notice must be in writing.

### *DCP Regulations and Report to the General Assembly (§§ 34 & 35)*

If a Canadian prescription drug importation program is established, the bill allows the DCP commissioner to adopt implementing regulations.

By 180 days after the first importation and biannually after that, the commissioner must submit a report to the Appropriations, General Law, Human Services, and Public Health committees describing the program operation, any violations that resulted in action being taken by the commissioner, and the status of any violation investigations.

### *Background — Related Bills*

sHB 6870 (File 308), §§ 1-10, favorably reported by the Insurance and Real Estate Committee, and sHB 7192, §§ 5-14, favorably reported by the Human Services Committee, both have substantially similar provisions related to establishing a Canadian prescription drug importation program.

## § 36 — PRESCRIPTION DRUG SHORTAGES TASK FORCE

*Creates a task force to study prescription drug shortage preparedness and mitigation*

The bill creates an ongoing task force to study emergency preparedness and mitigation strategies for prescription drug shortages. The task force must identify drugs at risk of shortage in this state and recommend ways to address that (see below).

EFFECTIVE DATE: Upon passage

### *Task Force Members, Administration, and Reporting Requirement*

The task force includes eight members appointed by the legislative leaders, as shown in the following table. Appointees may be legislators.

**Table: Task Force Appointed Members**

| *Appointing Authority* | *Appointee Qualifications* |
|---|---|
| House speaker | Expert in prescription drug supply chains<br>Expert in federal law on prescription drug shortages |
| Senate president pro tempore | Representative of hospitals<br>Representative of providers who treat patients with rare diseases |
| House majority leader | Representative of the Mohegan or Mashantucket Pequot tribe |
| Senate majority leader | Representative of the Mohegan or Mashantucket Pequot tribe |
| House minority leader | Unspecified qualifications |
| Senate minority leader | Unspecified qualifications |

The task force also includes the following officials or their designees: the DCP, economic and community development (DECD), health strategy, insurance, public health, and social services commissioners and UConn Health Center's chief executive officer.

Appointing authorities must make their initial appointments within 30 days after the bill's passage and fill any vacancy.

The House speaker and Senate president pro tempore must select the task force chairpersons from among its members. The chairpersons must schedule and hold the first meeting within 60 days after the bill's passage. The Human Services Committee's administrative staff serves in that capacity for the task force.

The bill requires the task force, starting by January 1, 2026, to annually report its findings and recommendations to the General Law, Human Services, Insurance and Real Estate, and Public Health committees. The reports must identify (1) those drugs the task force determines are at risk of shortage and (2) strategies to mitigate these shortages, including ways to increase in-state production of drugs that are at risk of shortage and critically necessary for health care in the state.

### *Background — Related Bill*

sHB 7192, § 15, favorably reported by the Human Services Committee, has substantially similar provisions creating a prescription drug shortages task force.

## § 37 — STRATEGIC SUPPLY CHAIN INITIATIVE

*Requires DECD to incorporate prescription drug shortage prevention or mitigation into its Strategic Supply Chain Initiative*

The bill requires the DECD commissioner to expand the department's Strategic Supply Chain Initiative to include efforts to prevent or mitigate prescription drug shortages. This must include incorporating the task force's recommendations (see § 36).

Under the bill, this initiative is a DECD-administered program to help state-based companies increase their production capacity to win new business and attract out-of-state and international supply chain operations.

EFFECTIVE DATE: July 1, 2025

### *Background — Related Bill*

HB 7192, § 16, favorably reported by the Human Services Committee, has identical provisions on DECD's Strategic Supply Chain Initiative.

## § 38 — VACCINES AND RELATED BIOLOGICAL PRODUCTS ADVISORY COMMITTEE

*Requires DPH to convene an advisory committee to coordinate seasonal vaccine production along with drug manufacturers*

The bill requires the public health commissioner to establish and convene a Vaccines and Related Biological Products Advisory Committee to coordinate seasonal vaccine production with pharmaceutical manufacturers.

Under the bill, the commissioner must appoint representatives of the following groups:

1. pharmaceutical manufacturers, including one large manufacturer and one small or start-up one;

2. health systems, including at least one large or statewide hospital system and one federally qualified health center; and

3. physicians, including at least one expert each in infectious disease epidemiology, disease ecology, biostatistics or infectious disease modeling, and an expert in immunology or virology.

The bill requires the committee to meet within 30 days after the bill's passage. The committee has two chairpersons: the DPH commissioner or her designee, and another elected by the committee. The commissioner must fill any vacancy.

Starting by September 1, 2025, the commissioner must annually file a report with the Human Services and Public Health committees on the advisory committee's activities and recommendations and its impact on state preparedness for the annual flu season.

EFFECTIVE DATE: Upon passage

## COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 15 Nay 7 (03/13/2025)