



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:

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

3 (1) "Biological product" has the same meaning as provided in section
4 20-619 of the general statutes;

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

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

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

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

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

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

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

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

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

36 (10) "Prescription drug" means a legend drug, as defined in section
37 20-571 of the general statutes, approved by the federal Food and Drug
38 Administration, or any successor agency, and prescribed by a health
39 care provider to an individual in this state;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

329 (b) Not later than September 1, 2025, the chief executive officer of The
330 University of Connecticut Health Center, or the chief executive officer's
331 designee, shall file a report, in accordance with the provisions of section
332 11-4a of the general statutes, with the joint standing committees of the
333 General Assembly having cognizance of matters relating to general law,
334 human services and public health on any savings realized from bulk
335 purchases of prescription drugs pursuant to subsection (a) of this
336 section.

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

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

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

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

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

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

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

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

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

- 373 (6) One appointed by the minority leader of the Senate;
- 374 (7) The Commissioner of Health Strategy, or the commissioner's
375 designee;
- 376 (8) The Commissioner of Social Services, or the commissioner's
377 designee;
- 378 (9) The Commissioner of Consumer Protection, or the commissioner's
379 designee;
- 380 (10) The Insurance Commissioner, or the commissioner's designee;
381 and
- 382 (11) The Commissioner of Children and Families, or the
383 commissioner's designee.
- 384 (c) Any member of the council appointed under subdivision (1), (2),
385 (3), (4), (5) or (6) of subsection (b) of this section may be a member of the
386 General Assembly.
- 387 (d) All initial appointments to the council shall be made not later than
388 thirty days after the effective date of this section. Any vacancy shall be
389 filled by the appointing authority.
- 390 (e) The speaker of the House of Representatives and the president pro
391 tempore of the Senate shall select the chairpersons of the council from
392 among the members of the council. Such chairpersons shall schedule the
393 first meeting of the council, which shall be held not later than sixty days
394 after the effective date of this section.
- 395 (f) The administrative staff of the joint standing committee of the
396 General Assembly having cognizance of matters relating to human
397 services shall serve as administrative staff of the council.
- 398 (g) Not later than January 1, 2026, and annually thereafter, the council
399 shall submit a report on its findings and recommendations to the
400 Commissioner of Health Strategy and the joint standing committees of
401 the General Assembly having cognizance of matters relating to general

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

404 Sec. 7. Subsection (a) of section 17b-340d of the general statutes is
405 repealed and the following is substituted in lieu thereof (*Effective July 1,*
406 *2025*):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

530 (11) There shall be no increase to rates based on inflation or any
531 inflationary factor for the fiscal years ending June 30, 2022, and June 30,
532 2023, unless otherwise authorized under subdivision (1) of this
533 subsection. Notwithstanding section 17-311-52 of the regulations of
534 Connecticut state agencies, for the fiscal years ending June 30, 2024, and

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

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

565 [(12)] (13) For purposes of computing minimum allowable patient
566 days, utilization of a facility's certified beds shall be determined at a
567 minimum of ninety per cent of capacity, except for facilities that have
568 undergone a change in ownership, new facilities, and facilities which

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

572 [(13)] (14) Rates determined under this section shall comply with
573 federal laws and regulations.

574 [(14)] (15) The Commissioner of Social Services may authorize an
575 interim rate for a facility demonstrating circumstances particular to that
576 individual facility impacting facility finances or costs not reflected in the
577 underlying rates.

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

587 (b) The Commissioner of Social Services shall expand emergency
588 Medicaid coverage consistent with federal law for treatment of
589 emergency medical conditions, including, but not limited to, emergency
590 medical conditions related to (1) a high-risk pregnancy, (2) diabetes type
591 1 in persons under the age of twenty-one, (3) diabetic emergencies,
592 including, but not limited to, diabetic ketoacidosis, (4) renal failure
593 requiring ongoing dialysis, (5) fracture of a bone in the skull, arm, neck,
594 leg, spine or pelvis occurring in the two-month period prior to a request
595 for emergency Medicaid coverage, (6) hypertensive emergencies
596 involving persons presenting with signs or symptoms of end organ
597 damage and systolic blood pressure equaling or exceeding one hundred
598 eighty or diastolic blood pressure equaling or exceeding one hundred
599 twenty, (7) unstable seizure disorder characterized by at least five
600 minutes of uncontrollable seizures or at least two discrete seizures
601 between which the person does not regain consciousness, (8) active

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

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

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

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

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

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

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

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

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

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

643 (c) Not later than July 1, 2026, and annually thereafter until July 1,
644 2030, the commissioner shall file a report, in accordance with the
645 provisions of section 11-4a of the general statutes, with the joint
646 standing committees of the General Assembly having cognizance of
647 matters relating to appropriations and the budgets of state agencies and
648 human services on (1) the number of persons eligible for the HUSKY C
649 health program for the prior fiscal year, and (2) any increased costs
650 incurred by the state that are attributable to changes in the asset limits.

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

652 (1) "General anesthesia" has the same meaning as provided in section
653 20-123a of the general statutes; and

654 (2) "Medical necessity" has the same meaning as provided in section
655 38a-482a of the general statutes.

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

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

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

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

672 (1) "General anesthesia" has the same meaning as provided in section
673 20-123a of the general statutes; and

674 (2) "Medical necessity" has the same meaning as provided in section
675 38a-482a of the general statutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

751 (2) "Body mass index", or "BMI", means the number calculated by
752 dividing an individual's weight in kilograms by the individual's height
753 in meters squared;

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

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

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

759 (A) Greater than forty; or

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

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

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

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

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

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

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

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

805 (1) "340B drug" means a drug that (A) is a covered outpatient drug
806 within the meaning of 42 USC 256b; (B) has been subject to any offer for
807 reduced prices by a manufacturer under 42 USC 256b(a)(1); and (C) is
808 purchased by a covered entity. "340B drug" includes a drug that would
809 have been purchased but for the restriction or limitation described in
810 subsection (a) of section 18 of this act;

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

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

816 (4) "Manufacturer" has the same meaning as provided in section 21a-
817 70 of the general statutes, except that such definition shall include

818 manufacturers of biologics;

819 (5) "Package" has the same meaning as provided in 21 USC
820 360eee(11)(A); and

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

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

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

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

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

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

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

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

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

875 (1) Applicable federal law and related regulations, including 21 USC
876 355-1, as amended from time to time; or

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

879 (d) The Commissioner of Consumer Protection shall adopt

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

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

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

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

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

900 (1) "Health benefit plan" has the same meaning as provided in section
901 38a-472f of the general statutes;

902 (2) "Insulin" means an insulin product, including, but not limited to,
903 an insulin pen or vial, that is licensed under 42 USC 262(a) or 42 USC
904 262(k), as amended from time to time;

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

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

910 discounts required by state or federal law, including Medicaid,
911 Medicare and Section 340B of the Public Health Service Act, 42 USC
912 256b, as amended from time to time, and (B) rebates or discounts related
913 to portfolio agreements that relate to purchase of multiple insulin
914 products or other drugs;

915 (5) "State entity" means any state agency, or any person acting on
916 behalf of the state, that purchases a prescription drug for an individual
917 with health insurance paid for by the state, including health insurance
918 offered by local, state or federal agencies, or through organizations
919 licensed in the state;

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

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

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

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

942 (a) For the purposes of this section:

943 (1) "Diabetes device" has the same meaning as provided in section 20-
944 616;

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

947 (3) "Glucagon drug" has the same meaning as provided in section 20-
948 616;

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

951 (5) "Insulin drug" has the same meaning as provided in section 20-
952 616;

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

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

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

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

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

971 once during a policy year;

972 (3) Noninsulin drugs (A) prescribed by a prescribing practitioner, or
973 (B) prescribed and dispensed pursuant to subsection (d) of section 20-
974 616 once during a policy year if the noninsulin drug is a glucagon drug;

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

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

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

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

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

996 (3) One hundred dollars for a thirty-day supply of all medically
997 necessary covered diabetes devices and diabetic ketoacidosis devices for
998 such insured that are in accordance with such insured's diabetes
999 treatment plan, including, but not limited to, diabetes devices and
1000 diabetic ketoacidosis devices prescribed and dispensed pursuant to
1001 subsection (d) of section 20-616 once during a policy year.

1002 (d) Notwithstanding the provisions of subsection (c) of this section
1003 and section 38a-492a, on and after January 1, 2026, any policy described
1004 in subsection (b) of this section shall make available in a preferred tier
1005 with no copayment or out-of-pocket cost an eligible insulin product, as
1006 defined in section 20 of this act, at the lowest wholesale acquisition cost
1007 in accordance with section 20 of this act.

1008 ~~[(d)]~~ (e) The provisions of ~~[subsection (c)]~~ subsections (c) and (d) of
1009 this section shall apply to a high deductible health plan to the maximum
1010 extent permitted by federal law, except if such plan is used to establish
1011 a medical savings account or an Archer MSA pursuant to Section 220 of
1012 the Internal Revenue Code of 1986, or any subsequent corresponding
1013 internal revenue code of the United States, as amended from time to
1014 time, or a health savings account pursuant to Section 223 of said Internal
1015 Revenue Code, as amended from time to time, the provisions of said
1016 ~~[subsection (c)]~~ subsections shall apply to such plan to the maximum
1017 extent that (1) is permitted by federal law, and (2) does not disqualify
1018 such account for the deduction allowed under said Section 220 or 223,
1019 as applicable.

1020 Sec. 22. Section 38a-518d of the general statutes is repealed and the
1021 following is substituted in lieu thereof (*Effective January 1, 2026*):

1022 (a) For the purposes of this section:

1023 (1) "Diabetes device" has the same meaning as provided in section 20-
1024 616;

1025 (2) "Diabetic ketoacidosis device" has the same meaning as provided
1026 in section 20-616;

1027 (3) "Glucagon drug" has the same meaning as provided in section 20-
1028 616;

1029 (4) "High deductible health plan" has the same meaning as that term
1030 is used in subsection (f) of section 38a-520;

1031 (5) "Insulin drug" has the same meaning as provided in section 20-

1032 616;

1033 (6) "Noninsulin drug" means a drug, including, but not limited to, a
1034 glucagon drug, glucose tablet or glucose gel, that does not contain
1035 insulin and is approved by the federal Food and Drug Administration
1036 to treat diabetes; and

1037 (7) "Prescribing practitioner" has the same meaning as provided in
1038 section 20-571.

1039 (b) Notwithstanding the provisions of section 38a-518a, each group
1040 health insurance policy providing coverage of the type specified in
1041 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,
1042 issued for delivery, renewed, amended or continued in this state shall
1043 provide coverage for the treatment of all types of diabetes. Such
1044 coverage shall include, but need not be limited to, coverage for
1045 medically necessary:

1046 (1) Laboratory and diagnostic testing and screening, including, but
1047 not limited to, hemoglobin A1c testing and retinopathy screening, for
1048 all types of diabetes;

1049 (2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B)
1050 prescribed and dispensed pursuant to subsection (d) of section 20-616
1051 once during a policy year;

1052 (3) Noninsulin drugs (A) prescribed by a prescribing practitioner, or
1053 (B) prescribed and dispensed pursuant to subsection (d) of section 20-
1054 616 once during a policy year if the noninsulin drug is a glucagon drug;

1055 (4) Diabetes devices in accordance with the insured's diabetes
1056 treatment plan, including, but not limited to, diabetes devices
1057 prescribed and dispensed pursuant to subsection (d) of section 20-616
1058 once during a policy year; and

1059 (5) Diabetic ketoacidosis devices in accordance with the insured's
1060 diabetes treatment plan, including, but not limited to, diabetic
1061 ketoacidosis devices prescribed and dispensed pursuant to subsection

1062 (d) of section 20-616 once during a policy year.

1063 (c) Notwithstanding the provisions of section 38a-518a, no policy
1064 described in subsection (b) of this section shall impose coinsurance,
1065 copayments, deductibles and other out-of-pocket expenses on an
1066 insured that exceed:

1067 (1) Twenty-five dollars for each thirty-day supply of a medically
1068 necessary covered insulin drug (A) prescribed to the insured by a
1069 prescribing practitioner, or (B) prescribed and dispensed pursuant to
1070 subsection (d) of section 20-616 once during a policy year;

1071 (2) Twenty-five dollars for each thirty-day supply of a medically
1072 necessary covered noninsulin drug (A) prescribed to the insured by a
1073 prescribing practitioner, or (B) prescribed and dispensed pursuant to
1074 subsection (d) of section 20-616 once during a policy year if such
1075 noninsulin drug is a glucagon drug;

1076 (3) One hundred dollars for a thirty-day supply of all medically
1077 necessary covered diabetes devices and diabetic ketoacidosis devices for
1078 such insured that are in accordance with such insured's diabetes
1079 treatment plan, including, but not limited to, diabetes devices and
1080 diabetic ketoacidosis devices prescribed and dispensed pursuant to
1081 subsection (d) of section 20-616 once during a policy year.

1082 (d) Notwithstanding the provisions of subsection (c) of this section
1083 and section 38a-518a, on and after January 1, 2026, any policy described
1084 in subsection (b) of this section shall make available in a preferred tier
1085 with no copayment or out-of-pocket cost an eligible insulin product, as
1086 defined in section 20 of this act, at the lowest wholesale acquisition cost
1087 in accordance with section 20 of this act.

1088 [(d)] (e) The provisions of [subsection (c)] subsections (c) and (d) of
1089 this section shall apply to a high deductible health plan to the maximum
1090 extent permitted by federal law, except if such plan is used to establish
1091 a medical savings account or an Archer MSA pursuant to Section 220 of
1092 the Internal Revenue Code of 1986, or any subsequent corresponding

1093 internal revenue code of the United States, as amended from time to
1094 time, or a health savings account pursuant to Section 223 of said Internal
1095 Revenue Code, as amended from time to time, the provisions of said
1096 [subsection (c)] subsections shall apply to such plan to the maximum
1097 extent that (1) is permitted by federal law, and (2) does not disqualify
1098 such account for the deduction allowed under said Section 220 or 223,
1099 as applicable.

1100 Sec. 23. (NEW) (*Effective October 1, 2025*) (a) Any pharmacy benefits
1101 manager shall owe a fiduciary duty to any health carrier, as defined in
1102 section 38a-591a of the general statutes, or other health benefit plan
1103 sponsor.

1104 (b) Any pharmacy benefits manager shall notify the health carrier or
1105 other health benefit plan sponsor, in writing, of any activity, policy or
1106 practice of such pharmacy benefits manager that directly or indirectly
1107 presents any conflict of interest with the duties imposed by this section.

1108 (c) Any pharmacy benefits manager shall have an obligation of good
1109 faith and fair dealing in performing such pharmacy benefits manager's
1110 duties with all parties, including, but not limited to, a health carrier or
1111 other health benefit plan sponsor with whom such pharmacy benefits
1112 manager interacts in the performance of pharmacy benefit management
1113 services.

1114 (d) Notwithstanding any provision of title 38a of the general statutes
1115 and to the maximum extent permitted by applicable law, no contract
1116 entered into or amended by a health carrier shall contain any provision
1117 that permits or requires any party to such contract to violate the
1118 fiduciary duty that such health carrier owes to such health carrier's
1119 covered persons.

1120 (e) Any violation of the provisions of this section shall constitute a
1121 violation of sections 38a-815 to 38a-819, inclusive, of the general statutes.

1122 (f) The Insurance Commissioner may adopt regulations, in
1123 accordance with the provisions of chapter 54 of the general statutes, to

1124 implement the provisions of this section.

1125 Sec. 24. Section 38a-477cc of the general statutes is repealed and the
1126 following is substituted in lieu thereof (*Effective January 1, 2026*):

1127 (a) No contract for pharmacy services entered into in the state
1128 between a health carrier, as defined in section 38a-591a, or pharmacy
1129 benefits manager, as defined in section 38a-479aaa, and a pharmacy or
1130 pharmacist shall:

1131 (1) On and after January 1, 2018, contain a provision prohibiting or
1132 penalizing, including through increased utilization review, reduced
1133 payments or other financial disincentives, a pharmacist's disclosure to
1134 an individual purchasing prescription medication of information
1135 regarding:

1136 (A) The cost of the prescription medication to the individual; or

1137 (B) The availability of any therapeutically equivalent alternative
1138 medications or alternative methods of purchasing the prescription
1139 medication, including, but not limited to, paying a cash price, that are
1140 less expensive than the cost of the prescription medication to the
1141 individual; [and]

1142 (2) On and after January 1, 2020, contain a provision permitting the
1143 health carrier or pharmacy benefits manager to recoup, directly or
1144 indirectly, from a pharmacy or pharmacist any portion of a claim that
1145 such health carrier or pharmacy benefits manager has paid to the
1146 pharmacy or pharmacist, unless such recoupment is permitted under
1147 section 38a-479iii or required by applicable law;

1148 (3) On and after January 1, 2026, contain a provision permitting the
1149 pharmacy benefits manager to charge a health benefit plan in this state
1150 a contracted price for any pharmacy services that differs from the
1151 amount such pharmacy benefits manager, directly or indirectly, pays
1152 the pharmacy for such pharmacy services; and

1153 (4) On and after January 1, 2026, contain a provision permitting the

1154 pharmacy benefits manager to charge a health benefit plan, directly or
1155 indirectly, a fee that is conditioned on the (A) wholesale acquisition cost
1156 or any other price metric for a prescription drug, (B) amount of savings,
1157 rebates or other fees charged, realized, collected by or generated based
1158 on the business practices of such pharmacy benefits manager, or (C)
1159 amount of premiums charged or cost-sharing requirements pursuant to
1160 such health benefit plan that are realized or collected by such pharmacy
1161 benefits manager from covered persons. For the purposes of this
1162 subdivision, "wholesale acquisition cost" means the price of a
1163 medication set by a pharmaceutical manufacturer in the United States
1164 when selling to a wholesaler.

1165 (b) (1) On and after January 1, 2018, no health carrier or pharmacy
1166 benefits manager shall require an individual to make a payment at the
1167 point of sale for a covered prescription medication in an amount greater
1168 than the lesser of:

1169 (A) The applicable copayment for such prescription medication;

1170 (B) The allowable claim amount for the prescription medication; or

1171 (C) The amount an individual would pay for the prescription
1172 medication if the individual purchased the prescription medication
1173 without using a health benefit plan, as defined in section 38a-591a, or
1174 any other source of prescription medication benefits or discounts.

1175 (2) For the purposes of this subsection, "allowable claim amount"
1176 means the amount the health carrier or pharmacy benefits manager has
1177 agreed to pay the pharmacy for the prescription medication.

1178 (c) Any provision of a contract that violates the provisions of this
1179 section shall be void and unenforceable. Any general business practice
1180 that violates the provisions of this section shall constitute an unfair trade
1181 practice pursuant to chapter 735a. The invalidity or unenforceability of
1182 any contract provision under this subsection shall not affect any other
1183 provision of the contract.

1184 (d) The Insurance Commissioner may:

1185 (1) Enforce the provisions of this section pursuant to chapter 697; and

1186 (2) Upon request, audit a contract for pharmacy services for
1187 compliance with the provisions of this section.

1188 Sec. 25. (NEW) (*Effective July 1, 2025*) (a) The Insurance Commissioner
1189 shall require any health carrier, as defined in section 38a-591a of the
1190 general statutes, to report to the commissioner annually on pricing
1191 offered to and profit generated between such carrier and any pharmacy
1192 benefits manager or mail-order pharmacy doing business with such
1193 carrier.

1194 (b) The commissioner shall post a link on the Internet web site of the
1195 Insurance Department to the reports filed pursuant to subsection (a) of
1196 this section.

1197 Sec. 26. (*Effective July 1, 2025*) For the purposes of this section and
1198 sections 27 to 35, inclusive, of this act, unless the context otherwise
1199 requires:

1200 (1) "Canadian supplier" means a manufacturer or wholesale drug
1201 distributor that is licensed or permitted under applicable Canadian law
1202 to manufacture or distribute prescription drugs;

1203 (2) "Canadian prescription drug importation program" or "program"
1204 means a program under which the state would seek federal approval to
1205 import prescription drugs from Canada that have the highest potential
1206 for cost savings in the state;

1207 (3) "Department" means the Department of Consumer Protection;

1208 (4) "Drug" means an article that is (A) recognized in the official United
1209 States Pharmacopoeia, official Homeopathic Pharmacopoeia of the
1210 United States or official National Formulary, or any supplement thereto,
1211 (B) intended for use in the diagnosis, cure, mitigation, treatment or
1212 prevention of disease in humans, (C) not food and intended to affect the
1213 structure or any function of the human body, and (D) not a device and
1214 intended for use as a component of any article specified in

1215 subparagraphs (A) to (C), inclusive, of this subdivision;

1216 (5) "Drug Quality and Security Act" means the federal Drug Quality
1217 and Security Act, 21 USC 351, et seq., as amended from time to time;

1218 (6) "Food, Drug and Cosmetic Act" means the federal Food, Drug and
1219 Cosmetic Act, 21 USC 301, et seq., as amended by the Drug Quality and
1220 Security Act, as both may be amended from time to time;

1221 (7) "Qualifying laboratory" has the same meaning as provided in 21
1222 CFR 251.2;

1223 (8) "Laboratory testing" means a quantitative and qualitative analysis
1224 of a drug consistent with the applicable provisions of the official United
1225 States Pharmacopoeia;

1226 (9) "Participating Canadian supplier" means a Canadian supplier that
1227 is exporting prescription drugs, in the manufacturer's original
1228 container, to a participating wholesaler for distribution in this state
1229 under the program;

1230 (10) "Participating wholesaler" means a wholesaler that is (A)
1231 designated by the Department of Consumer Protection to distribute
1232 prescription drugs in the manufacturer's original container, obtained
1233 from a participating Canadian supplier, and (B) participating in the
1234 program;

1235 (11) "Recall" means a person's removal or correction of a marketed
1236 product that the department determines is in violation of this section,
1237 but "recall" does not include a market withdrawal or a stock recovery,
1238 as such terms are defined in 21 CFR 7.3;

1239 (12) "Relabeler" has the same meaning as provided in 21 CFR 207.1;

1240 (13) "Repacker" has the same meaning as provided in 21 CFR 207.1;

1241 (14) "Track-and-trace" means the product tracing process for the
1242 components of the pharmaceutical distribution supply chain as
1243 described in Title II of the Drug Quality and Security Act; and

1244 (15) "Wholesaler" means a wholesaler, as defined in section 21a-70 of
1245 the general statutes, that has received a certificate of registration from
1246 the Commissioner of Consumer Protection pursuant to said section.

1247 Sec. 27. (*Effective July 1, 2025*) The Commissioner of Consumer
1248 Protection shall hire, within available resources, a consultant to study
1249 the feasibility of establishing a Canadian prescription drug importation
1250 program to reduce prescription drug costs in the state. Not later than
1251 October 1, 2027, the commissioner shall file a report, in accordance with
1252 the provisions of section 11-4a of the general statutes, with the joint
1253 standing committees of the General Assembly having cognizance of
1254 matters relating to appropriations and the budgets of state agencies,
1255 general law and human services and the Office of Policy and
1256 Management on the results of the feasibility study.

1257 Sec. 28. (*Effective October 1, 2027*) (a) If after completion of the study
1258 described in section 27 of this act, the Commissioner of Consumer
1259 Protection, in consultation with the Secretary of the Office of Policy and
1260 Management, determines a Canadian prescription drug importation
1261 program is feasible, the Commissioner of Consumer Protection may
1262 submit a request to the federal Food and Drug Administration seeking
1263 approval for the program under Section 804 of the federal Food, Drug
1264 and Cosmetic Act, 21 USC 384(b) to 21 USC 384(h), inclusive, as
1265 amended from time to time. If submitted, such request shall, at a
1266 minimum:

1267 (1) Describe the state's plans for operating the program and describe
1268 any opportunities to coordinate or operate the program in coordination
1269 with other states;

1270 (2) Demonstrate that any prescription drug that is imported and
1271 distributed in this state under the program would:

1272 (A) Meet all applicable federal and state standards for safety and
1273 effectiveness; and

1274 (B) Comply with all federal tracing procedures; and

1275 (3) State the estimated costs of implementing the program.

1276 (b) If the federal Food and Drug Administration approves the
1277 request, the Commissioner of Consumer Protection shall:

1278 (1) Submit to the Secretary of the Office of Policy and Management,
1279 and the Commissioners of Social Services and Health Strategy, a notice
1280 disclosing that the federal Food and Drug Administration approved
1281 such request; and

1282 (2) Submit to the joint standing committees of the General Assembly
1283 having cognizance of matters relating to appropriations and the budgets
1284 of state agencies, general law, human services and public health a notice
1285 disclosing that the federal Food and Drug Administration approved
1286 such request.

1287 (c) The Commissioner of Consumer Protection shall not operate the
1288 program unless the federal Food and Drug Administration approves the
1289 request. Notwithstanding the provisions of this subsection, the
1290 department may expend resources in advance of such approval to
1291 ensure efficient implementation.

1292 Sec. 29. (*Effective October 1, 2027*) If the Canadian prescription drug
1293 importation program is established, each participating wholesaler may
1294 import and distribute a prescription drug in this state from a
1295 participating Canadian supplier under the program if:

1296 (1) Such drug meets the federal Food and Drug Administration's
1297 standards concerning drug safety, effectiveness, misbranding and
1298 adulteration;

1299 (2) Importing such drug would not violate federal patent laws; and

1300 (3) Such drug is not:

1301 (A) A controlled substance, as defined in 21 USC 802, as amended
1302 from time to time;

1303 (B) A biological product, as defined in 42 USC 262, as amended from

1304 time to time;

1305 (C) An infused drug;

1306 (D) An intravenously injected drug;

1307 (E) A drug that is inhaled during surgery; or

1308 (F) A drug that is a parenteral drug, the importation of which is
1309 determined by the federal Secretary of Health and Human Services to
1310 pose a threat to the public health.

1311 Sec. 30. (*Effective October 1, 2027*) If a Canadian prescription drug
1312 importation program is established, participating wholesalers may,
1313 subject to the provisions of sections 31 and 32 of this act, import and
1314 distribute drugs in this state from a participating Canadian supplier
1315 under the program to:

1316 (1) A pharmacy or institutional pharmacy, as defined in section 20-
1317 571 of the general statutes; and

1318 (2) A qualifying laboratory.

1319 Sec. 31. (*Effective October 1, 2027*) If a Canadian prescription drug
1320 importation program is established, the Commissioner of Consumer
1321 Protection shall require that each participating Canadian supplier and
1322 participating wholesaler (1) comply with all applicable track-and-trace
1323 requirements, and shall not distribute, dispense or sell outside of this
1324 state any prescription drug that is imported into this state under the
1325 program, and (2) make available to the commissioner all track-and-trace
1326 records not later than forty-eight hours after the commissioner requests
1327 such records.

1328 Sec. 32. (*Effective October 1, 2027*) (a) A participating wholesaler in any
1329 approved Canadian prescription drug importation program shall
1330 ensure the safety and quality of all drugs that may be imported and
1331 distributed in this state under the program. The participating
1332 wholesaler shall, if such program is established:

1333 (1) For each initial shipment of a drug that is imported into this state
1334 by a participating wholesaler, ensure that a qualifying laboratory
1335 engaged by the participating wholesaler tests a statistically valid sample
1336 size for each batch of each drug in such shipment for authenticity and
1337 degradation in a manner that is consistent with the Food, Drug and
1338 Cosmetic Act;

1339 (2) For each shipment of a drug that is imported into this state by a
1340 participating wholesaler and has been sampled and tested pursuant to
1341 subdivision (1) of this subsection, ensure that a qualifying laboratory
1342 engaged by the participating wholesaler tests a statistically valid sample
1343 of such shipment for authenticity and degradation in a manner that is
1344 consistent with the Food, Drug and Cosmetic Act;

1345 (3) Only import drugs into this state that are (A) approved for
1346 marketing in the United States, (B) not adulterated or misbranded, and
1347 (C) meet all of the labeling requirements under 21 USC 352, as amended
1348 from time to time;

1349 (4) Maintain qualifying laboratory records, including, but not limited
1350 to, complete data derived from all tests necessary to ensure that each
1351 drug imported into this state under any approved Canadian
1352 prescription drug importation program is in compliance with the
1353 requirements of this section; and

1354 (5) Maintain documentation demonstrating that the testing required
1355 by this section was conducted at a qualifying laboratory in accordance
1356 with the Food, Drug and Cosmetic Act and all other applicable federal
1357 and state laws and regulations concerning qualifying laboratory
1358 qualifications.

1359 (b) The participating wholesaler shall maintain all information and
1360 documentation pursuant to this section for a period of not less than three
1361 years from the date of submission of such information and
1362 documentation to the participating wholesaler by a qualifying
1363 laboratory.

1364 (c) Each participating wholesaler shall maintain all of the following
1365 information for each drug that such participating wholesaler imports
1366 and distributes in this state under the program, and submit such
1367 information to the Commissioner of Consumer Protection upon request
1368 by the commissioner:

1369 (1) The name and quantity of the active ingredient of such drug;

1370 (2) A description of the dosage form of such drug;

1371 (3) The date on which such participating wholesaler received such
1372 drug;

1373 (4) The quantity of such drug that such participating wholesaler
1374 received;

1375 (5) The point of origin and destination of such drug;

1376 (6) The price paid by such participating wholesaler for such drug;

1377 (7) A report regarding any drug that fails qualifying laboratory
1378 testing; and

1379 (8) Such additional information and documentation that the
1380 commissioner deems necessary to ensure the protection of the public
1381 health.

1382 (d) The Commissioner of Consumer Protection shall require each
1383 participating Canadian supplier in any approved Canadian prescription
1384 drug importation program to maintain the following information and
1385 documentation and, upon request by the commissioner, submit such
1386 information and documentation to the commissioner for each drug that
1387 such participating Canadian supplier exports into this state under the
1388 program:

1389 (1) The original source of such drug, including, but not limited to:

1390 (A) The name of the manufacturer of such drug;

- 1391 (B) The date on which such drug was manufactured; and
- 1392 (C) The location where such drug was manufactured;
- 1393 (2) The date on which such drug was shipped;
- 1394 (3) The quantity of such drug that was shipped;
- 1395 (4) The quantity of each lot of such drug originally received and the
1396 source of such lot;
- 1397 (5) The lot or control number and the batch number assigned to such
1398 drug by the manufacturer; and
- 1399 (6) Such additional information and documentation that the
1400 Commissioner of Consumer Protection deems necessary to ensure the
1401 protection of the public health.
- 1402 Sec. 33. (*Effective October 1, 2027*) (a) If the Commissioner of Consumer
1403 Protection determines that public health, safety or welfare requires
1404 emergency action, the commissioner may order a participating
1405 Canadian supplier, participating wholesaler, relabeler, repacker and
1406 qualifying laboratory to cease and desist from actions specified in the
1407 order that create the need for such emergency action pending
1408 administrative proceedings. Such cease and desist order shall be (1) in
1409 writing; (2) signed by the Commissioner of Consumer Protection; and
1410 (3) effective upon delivery to the respondent. An administrative
1411 proceeding in accordance with chapter 54 of the general statutes shall
1412 be promptly instituted following a cease and desist order. The
1413 commissioner may impose a civil penalty, in an amount not to exceed
1414 ten thousand dollars, after a hearing conducted pursuant to chapter 54
1415 of the general statutes.
- 1416 (b) The commissioner may require the recall, embargo or destruction,
1417 pursuant to section 21a-96 of the general statutes, of any drug that was
1418 imported and distributed under the program and has been identified as
1419 adulterated, within the meaning of section 21a-105 of the general
1420 statutes, or misbranded.

1421 (c) In the event of a cease and desist, recall, embargo or destruction
1422 order, the person adversely impacted by such order shall provide
1423 written notice to all other businesses participating in the program,
1424 informing them of the order.

1425 Sec. 34. (*Effective October 1, 2027*) If a Canadian prescription drug
1426 importation program is established, the Commissioner of Consumer
1427 Protection may adopt regulations in accordance with the provisions of
1428 chapter 54 of the general statutes to implement the provisions of sections
1429 29 to 33, inclusive, of this act.

1430 Sec. 35. (*Effective October 1, 2027*) Not later than one hundred eighty
1431 days after the first importation of any Canadian prescription drug under
1432 the importation program begins, and biannually thereafter, the
1433 Commissioner of Consumer Protection shall submit a report, in
1434 accordance with the provisions of section 11-4a of the general statutes,
1435 to the joint standing committees of the General Assembly having
1436 cognizance of matters relating to appropriations and the budgets of state
1437 agencies, general law, human services and public health. Such report
1438 shall describe (1) the operation of the program, if established, and (2)
1439 any violation of sections 29 to 33, inclusive, of this act that resulted in
1440 any action taken by the commissioner pursuant to section 33 of this act
1441 and the status of the investigation into such violation.

1442 Sec. 36. (NEW) (*Effective from passage*) (a) There is established a task
1443 force to study emergency preparedness and mitigation strategies for
1444 prescription drug shortages. The task force shall identify prescription
1445 drugs at risk of shortage in this state and make recommendations
1446 pursuant to subsection (g) of this section.

1447 (b) The task force shall consist of the following members:

1448 (1) Two appointed by the speaker of the House of Representatives,
1449 one of whom has expertise in prescription drug supply chains and one
1450 of whom has expertise in federal law concerning prescription drug
1451 shortages;

1452 (2) Two appointed by the president pro tempore of the Senate, one of
1453 whom represents hospitals and one of whom represents health care
1454 providers who treat patients with rare diseases;

1455 (3) One appointed by the majority leader of the House of
1456 Representatives, who represents one of the two federally recognized
1457 Indian tribes in the state;

1458 (4) One appointed by the majority leader of the Senate, who
1459 represents one of the two federally recognized Indian tribes in the state;

1460 (5) One appointed by the minority leader of the House of
1461 Representatives;

1462 (6) One appointed by the minority leader of the Senate;

1463 (7) The Commissioner of Health Strategy, or the commissioner's
1464 designee;

1465 (8) The Commissioner of Consumer Protection, or the commissioner's
1466 designee;

1467 (9) The Commissioner of Social Services, or the commissioner's
1468 designee;

1469 (10) The Commissioner of Public Health, or the commissioner's
1470 designee;

1471 (11) The chief executive officer of The University of Connecticut
1472 Health Center, or the chief executive officer's designee;

1473 (12) The Insurance Commissioner, or the commissioner's designee;
1474 and

1475 (13) The Commissioner of Economic and Community Development,
1476 or the commissioner's designee.

1477 (c) Any member of the task force appointed under subdivision (1),
1478 (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member

1479 of the General Assembly.

1480 (d) All initial appointments to the task force shall be made not later
1481 than thirty days after the effective date of this section. Any vacancy shall
1482 be filled by the appointing authority.

1483 (e) The speaker of the House of Representatives and the president pro
1484 tempore of the Senate shall select the chairpersons of the task force from
1485 among the members of the task force. Such chairpersons shall schedule
1486 the first meeting of the task force, which shall be held not later than sixty
1487 days after the effective date of this section.

1488 (f) The administrative staff of the joint standing committee of the
1489 General Assembly having cognizance of matters relating to human
1490 services shall serve as administrative staff of the task force.

1491 (g) Not later than January 1, 2026, and annually thereafter, the task
1492 force shall submit a report on its findings and recommendations to the
1493 joint standing committees of the General Assembly having cognizance
1494 of matters relating to general law, human services, insurance and real
1495 estate and public health, in accordance with the provisions of section 11-
1496 4a of the general statutes, including, but not limited to, identification of
1497 prescription drugs the task force determines are at risk of shortage and
1498 strategies that would mitigate these shortages, including methods to
1499 increase in-state production of such drugs deemed both at risk of
1500 shortage and critically necessary for the provision of health care within
1501 the state.

1502 Sec. 37. (NEW) (*Effective July 1, 2025*) (a) As used in this section,
1503 "Strategic Supply Chain Initiative" means a program administered by
1504 the Department of Economic and Community Development to help
1505 state-based companies to increase their production capacity to win new
1506 business and attract out-of-state and international supply chain
1507 operations.

1508 (b) The Commissioner of Economic and Community Development
1509 shall expand the Strategic Supply Chain Initiative to include efforts to

1510 prevent or mitigate prescription drug shortages, including, but not
1511 limited to, incorporating recommendations to prevent or mitigate
1512 prescription drug shortages by the task force established pursuant to
1513 section 36 of this act.

1514 Sec. 38. (NEW) (*Effective from passage*) (a) The Commissioner of Public
1515 Health shall establish and convene a Vaccines and Related Biological
1516 Products Advisory Committee for the purpose of coordinating seasonal
1517 vaccine production in coordination with pharmaceutical drug
1518 manufacturers.

1519 (b) The commissioner shall appoint to the advisory committee
1520 representatives of (1) pharmaceutical manufacturers, including one
1521 large such manufacturer and one small or start-up such manufacturer;
1522 (2) health systems, including, but not limited to, one large or state-wide
1523 hospital system and one federally qualified health center; and (3)
1524 physicians, including, but not limited to, one expert each in infectious
1525 disease epidemiology, disease ecology, biostatistics or infectious disease
1526 modeling, and an expert in immunology or virology.

1527 (c) The advisory committee shall be appointed and meet not later
1528 than thirty days after the effective date of this act. The chairpersons shall
1529 be the commissioner, or the commissioner's designee, and a member of
1530 the committee elected by the committee. Any vacancy shall be filled by
1531 the commissioner.

1532 (d) Not later than September 1, 2025, and annually thereafter, the
1533 commissioner shall file a report, in accordance with the provisions of
1534 section 11-4a of the general statutes, with the joint standing committees
1535 of the General Assembly having cognizance of matters relating to
1536 human services and public health on the activities and
1537 recommendations of the advisory committee and impact on state
1538 preparedness for the annual flu season.

This act shall take effect as follows and shall amend the following sections:
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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-278l
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

¹The 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 \$3,300² while the average marginal cost for supervision in the community is less than \$600³ 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

²Inmate 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.

³Probation 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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[SUMMARY](#)[§§ 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

[§§ 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

[§ 6 — PRESCRIPTION DRUG AFFORDABILITY COUNCIL](#)

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

[§ 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

[§ 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

§ 9 — PHASEOUT OF HUSKY C ASSET LIMIT

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

§§ 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

§ 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

§ 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

§ 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

§ 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

§ 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

§§ 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

§ 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

§§ 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

§ 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

§ 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

§ 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

§§ 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

§ 36 — PRESCRIPTION DRUG SHORTAGES TASK FORCE

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

§ 37 — STRATEGIC SUPPLY CHAIN INITIATIVE

Requires DECD to incorporate prescription drug shortage prevention or mitigation into its 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

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

<i>Appointing Authority</i>	<i>Appointee Qualifications</i>
House speaker	Hospital organization representative Physician organization representative
Senate president pro tempore	Academic who has researched prescription drug affordability 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

<i>Time Period</i>	<i>Single Person</i>	<i>Married Couple</i>
Current law	\$1,600	\$2,400
FY 26	\$10,000	\$15,000

<i>Time Period</i>	<i>Single Person</i>	<i>Married Couple</i>
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 (HHS) 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

<i>Appointing Authority</i>	<i>Appointee Qualifications</i>
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

<i>Appointing Authority</i>	<i>Appointee Qualifications</i>
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 health 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

<i>Appointing Authority</i>	<i>Appointee Qualifications</i>
House speaker	Expert in prescription drug supply chains Expert in federal law on prescription drug shortages
Senate president pro tempore	Representative of hospitals 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)