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ResearchReport

Pharmacy Benefit Managers - Connecticut Laws

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Issue

Summarize Connecticut laws regulating pharmacy benefit managers (PBM). (This report updates OLR Report 2024-R-0027.)

Summary

PBMs administer the prescription drug, prescription device, or pharmacist services portion of a health benefit plan on behalf of plan sponsors (e.g., self-insured employers, insurance companies, or HMOs). By law, PBMs must exercise good faith and fair dealing in performing their contractual duties under these arrangements.

Connecticut law requires PBMs to register with the Connecticut Insurance Department (CID) and comply with statutory requirements on things such as claim payments; pharmacy audits; and various contract provisions (including limits on gag clauses, prescription payments, and PBM recoupments). It also requires PBMs to provide annual reporting on drug rebates to CID which the department must publish annually. The law also prohibits certain provisions in contracts between PBMs and 340B covered entities (i.e. entities authorized to participate in the federal 340B Drug Pricing Program) and makes any such provisions void and unenforceable.

Additionally, under a 2023 legislation the Office of Health Strategy (OHS), in consultation with CID, was required to analyze PBMs' prescription drug distribution practices, including an (1) analysis of spread pricing arrangements, manufacturing rebates and transparency, fees, and financial incentives to add drugs to insurance formularies and (2) evaluation of PBMs' prescription drug

distribution practices in other states (PA 23-171, § 7). OHS was required to submit recommendations to the Insurance and Real Estate Committee on ways to (1) reduce consumers' prescription drug costs and (2) regulate in-state PBMs. The OHS report is available here: Connecticut Health Strategy: Report of Pharmacy Benefit Manager Practices (February 2025).

Lastly, under a new law, the insurance commissioner must require health carriers to annually report on pricing in effect for the prior year and profit generated between the carrier and any PBM or mail-order pharmacy doing business in Connecticut (PA 25-167, § 4, effective January 1, 2026).

PBM Definition

In Connecticut, a PBM is any person or entity that administers the prescription drug, prescription device, or pharmacist services portion of a health benefit plan on behalf of plan sponsors (CGS § 38a-479aaa).

PBM Duty of Good Faith and Fair Dealing

A new law requires PBMs to exercise good faith and fair dealing in performing their contractual duties to health carriers or other plan sponsors. It also specifies that a PBM has an obligation of good faith and fair dealing in performing its duties with all parties, including carriers and other plan sponsors. Under the new law, a PBM must notify the health carrier or plan sponsor, in writing, if any of the PBM's activities, policies, or practices directly or indirectly present a conflict of interest with these duties. It also authorizes the insurance commissioner to adopt implementing regulations (PA 25-167, § 1, effective October 1, 2025).

Registration and Oversight

Connecticut law requires PBMs to obtain a certificate of registration from the insurance commissioner before operating in the state, unless they are affiliated with a licensed health carrier (CGS § 38a-479bbb). Specifically, the law exempts from the registration requirement a PBM that is a line of business or affiliate of a Connecticut-licensed health insurer, HMO, hospital or medical service corporation, or fraternal benefit society. However, it requires these entities to notify the insurance commissioner annually that they are affiliated with or operating a business as a PBM. PBMs must renew their registration annually (CGS § 38a-479fff).

To apply for registration, a PBM must give CID a completed application, including information about the people running the PBM; a nonrefundable $50 fee; and evidence of a surety bond that equals 10% of one month of claims in the state over a 12-month average. The bond must be at least

$25,000 and no more than $1 million (CGS § 38a-479bbb). The PBM may request a hearing if the department denies registration (CGS § 38a-479ddd).

PBMs are subject to investigation by the insurance commissioner (CGS § 38a-479hhh). The law also permits the commissioner, after notice and hearing, to suspend, revoke, or deny registration for certain causes, including conduct that is likely to mislead, deceive, or defraud the public; unfair or deceptive business practices; or nonpayment of the renewal fee (CGS § 38a-479ccc). Anyone aggrieved by the commissioner's decisions may appeal to Superior Court (CGS § 38a-479hhh).

Claim Payments

PBMs must, upon written request from a pharmacy, pay claims to the pharmacy by electronic funds transfer. Claim payments must be made in a timely fashion (e.g., within 60 days from receipt for claims filed in a paper format and within 20 days from receipt for claims filed electronically) (CGS §§ 38a-479eee & 38a-816(15)(B)).

Copay Accumulator Programs

The law requires PBMs and health carriers, when calculating a covered individual's cost sharing liability (e.g., coinsurance, copayment, or deductible) for a covered benefit, to credit discounts provided and payments made by a third party for any portion of the cost sharing (CGS § 38a-477gg). (Thus, it prohibits copay accumulator programs, under which drug manufacturer coupons and copay assistance generally do not apply toward a covered individual's cost sharing responsibility.)

Pharmacy Audits

Connecticut law authorizes PBMs and health insurance plan sponsors to audit certain pharmacy records and specifies how they may do so (CGS § 38a-479iii). A pharmacy audit is an audit conducted of any pharmacy's records for prescription drugs or devices the pharmacy dispenses to a health insurance plan's beneficiaries.

The law establishes the duties of the auditing entity and how pharmacies can validate their records. It requires the auditing entity to give the audited pharmacy its preliminary findings as well as a final report and allows the pharmacy to appeal the final report. The law also limits when a pharmacy can be subjected to a charge-back or recoupment (e.g., cannot charge back for a clerical error unless it caused actual financial harm).

Contract Provisions

Gag Clauses Prohibited

The law prohibits a pharmacy services contract between a PBM or health carrier and a pharmacist or pharmacy from containing a provision prohibiting or penalizing a pharmacist's disclosure of certain information to an individual purchasing prescription medication (e.g., increased utilization review, reduced payments, or other financial disincentives). A contract cannot prohibit or penalize the disclosure of the (1) prescription's cost to the individual or (2) availability of any therapeutically equivalent alternative medications or alternative, less expensive methods of purchasing the prescription, including paying the cash price (CGS § 38a-477cc(a)(1)).

Limits on Prescription Payments

The law also prohibits a PBM or health carrier from requiring an individual to pay more for a covered prescription medication than the lesser of the (1) applicable copayment; (2) allowable claim amount (i.e. the amount the PBM or health carrier agreed to pay the pharmacy for the prescription); or (3) amount an individual would pay for the drug if he or she paid without using an insurance plan or other drug benefits or discounts (CGS § 38a-477cc(b)).

Additionally, starting January 1, 2026, PBMs must offer a health plan the option of being charged the same price for a prescription drug that the PBM pays a pharmacy for drugs (PA 25-167, § 2).

Recoupments

The law prohibits a contract between a PBM or health carrier and a pharmacy or pharmacist from allowing the PBM or health carrier to recoup, directly or indirectly, any portion of a claim it paid to the pharmacy or pharmacist, unless the payment is (1) due to a pharmacy audit (see above) or (2) required by another applicable law (CGS § 38a-477cc(a)(2)).

Violations and Enforcement

Any provision of a contract that violates the above contract provision requirements is void and unenforceable. (A contract provision rendered invalid or unenforceable does not affect remaining contract provisions.) Under the law, any general business practice that violates its provisions is an unfair trade practice under the Connecticut Unfair Trade Practices Act. Additionally, the law grants the insurance commissioner authority to enforce its provisions and audit pharmacy services contracts for compliance (CGS § 38a-477cc(c) & (d), as amended by PA 25-167, § 2)).

Contracts With 340B Covered Entities

Section 340B of the federal Public Health Service Act (i.e. the 340B Drug Pricing Program) requires drug manufacturers participating in Medicaid to sell certain outpatient prescription drugs at discounted prices to health care organizations that care for uninsured and low-income patients. These organizations include federally qualified health centers, children's hospitals, hospitals that serve a disproportionate number of low-income patients, and other safety net providers.

A 2023 state law made various changes affecting participants in the federal 340B drug pricing program, such as prohibiting certain provisions in contracts between 340B covered entities and PBMs. Under this law, "340B covered entities" are those entities authorized to participate in the program, including pharmacies under contract to dispense drugs on their behalf.

The law prohibits certain provisions in contracts between 340B covered entities and PBMs (including PBM subsidiaries). For example, it prohibits these contracts from providing lower reimbursement rates for prescription drugs than the rate paid to pharmacies that are not 340B covered entities.

Under this law, PBMs are also prohibited from:

1. considering whether an entity is a 340B covered entity when determining reimbursement rates, except to the extent allowed by law; and
2. retaliating against a 340B covered entity because it exercises a right or remedy under these provisions.

Any provisions of a contract between PBMs and 340B covered entities that violate the above provisions are void and unenforceable. This applies to contracts entered into, amended, or renewed after January 1, 2024 (PA 23-171, § 15; codified at CGS § 38a-479jjj).

Annual PBM Reporting on Drug Rebates

PBM Rebate Report to CID

The law requires PBMs to annually report certain rebate information to the insurance commissioner (CGS § 38a-479ppp). A "rebate" is a discount or concession impacting the price of an outpatient prescription drug that a manufacturer provides to a health carrier or PBM, excluding bona fide service fees.

A PBM must report specific rebate information related to health carriers that delivered, issued, renewed, amended, or continued a health care plan that included a pharmacy benefit the PBM managed during the prior calendar year. The report must provide the aggregate amount of:

1. drug formulary rebates the PBM collected from pharmaceutical manufacturers of covered outpatient prescription drugs attributable to patient utilization and
2. all rebates, excluding any portion of rebates described above that were received by health carriers.

The insurance commissioner (1) may impose a penalty of up to $7,500 on PBMs for each violation of the reporting requirement and (2) must annually report to the Insurance and Real Estate Committee an aggregation of the information submitted by PBMs and any other information he deems relevant.

The law exempts the rebate information submitted to the commissioner from disclosure under the Freedom of Information Act, except to the extent it is aggregated and included in the commissioner's report to the committee. The law also prohibits the commissioner from disclosing the information in a way that:

1. enables a third party to identify a health care plan, health carrier, PBM, pharmaceutical manufacturer, or the value of a rebate provided for a particular outpatient prescription drug or therapeutic class of outpatient prescription drugs or
2. is likely to compromise the information's financial, competitive, or proprietary nature.

Annual Reporting Deadlines

By law, PBMs must annually report prescription drug rebate information to the insurance commissioner by March 1; and the commissioner must annually report to the Insurance and Real Estate Committee on the PBMs' rebate reports by April 1 (CGS § 38a-479ppp, as amended by PA 25-132, § 2).

CID's Published 2025 PBM Rebate Report

As required under CGS § 38a-479ppp, CID annually publishes the aggregated data described above on its website here.

According to the 2025 report, which analyzes rebates during the 2024 calendar year, there was approximately $193 million in rebates collected by health carriers from pharmaceutical manufacturers, of which 1.1% ($2 million) was kept by PBMs.

Reporting on Pricing and Profit Between Carriers and PBMs

Effective January 1, 2026, the insurance commissioner must require health carriers to annually report on pricing in effect for the prior year and profit generated between the carrier and any PBM or mail-order pharmacy doing business in Connecticut provided the information is reasonably available and the commissioner keeps proprietary information confidential. This new law does not set a deadline for information to be reported to the commissioner (PA 25-167, § 4, effective January 1, 2026).

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