Prescription Drug Task Force

Final Report and Recommendations

February 26, 2025

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Introduction

The rising cost of prescription drugs presents a significant challenge to Connecticut residents, state healthcare programs, and policymakers alike. Nationwide, pharmaceutical expenditures have been increasing at an unsustainable rate, with drug prices rising nearly 16% between 2016 and 2021 – primarily due to price inflation rather than increased utilization.[1] These rising costs create barriers to accessing essential medications, disproportionately affecting lower-income populations and those managing chronic illnesses.

In response, Senators Matt Lesser and Jeff Gordon along with Representatives Jillian Gilchrest and Tracy Marra came together to form a task force to investigate the root causes of high drug prices, evaluate potential solutions, and develop policy recommendations aimed at improving affordability, transparency, and access. It was the chairs' hope that in convening a bipartisan, bicameral, highly inclusive group, the task force would be able to cut through deeply entrenched perspectives and find a way to lower the cost of vital medications to the end consumer. Connecticut is not alone in these efforts – states such as Colorado, Maryland, California, Washington, Ohio, and West Virginia have successfully implemented regulatory interventions which have yielded substantial cost savings.

The task force consisted of legislators, healthcare providers, pharmacists, patient advocates, pharmaceutical industry experts, insurers, manufacturers, pharmacy benefit managers, state agencies, and other key stakeholders. Over the course of several months, the task force conducted extensive research, gathered data, and engaged in wide-ranging deliberations to address systemic inefficiencies contributing to excessive drug costs. Pharmacy benefit managers

[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2023). *Trends in prescription drug spending, 2016-2021.* https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf

(PBMs), supply chain vulnerabilities, opportunities, & regulatory gaps, pricing schemes, existing discount programs, state purchasing protocols, patient needs, and market dynamics, were examined to identify barriers to affordability.

The following report outlines the chairs' findings, including an in-depth review of PBMs, prescription drug supply chains, pricing regulations, and alternative cost-saving mechanisms such as bulk purchasing programs and the federal 340B Drug Pricing Program. In the chairs' opinion, if properly balanced against market structures, these mechanisms have the potential to significantly reduce drug costs. By addressing these areas, this report provides detailed recommendations aimed at ensuring prescription drugs become and remain affordable and accessible for all Connecticut residents, particularly for vulnerable populations most affected by cost barriers.

Background on the Issue

Prescription drug spending in the United States has steadily increased, with many factors contributing to rising costs, including PBM practices, drug shortages, and opaque pricing models. Between 2016 and 2021, drug expenditures rose by nearly 16%, with pricing markups and complex rebate structures driving much of this increase rather than increased utilization.[2] These trends have raised concerns about affordability, particularly for individuals with chronic conditions who rely on life-sustaining medications and those enrolled in state-funded health programs.

One key issue driving price increases is the role of PBMs, intermediaries that negotiate drug prices between insurers, manufacturers, and pharmacies. While PBMs were originally designed to lower costs, recent analyses suggest that their rebate structures and pricing practices have instead contributed to higher drug prices, often benefiting corporate stakeholders rather than patients.[3] Many PBMs operate within vertically integrated health systems, creating conflicts of interest where affiliated entities – such as insurer-owned specialty pharmacies – help generate profit from inflated pricing schemes. Reports indicate that PBMs engage in spread pricing, charging insurers more for drugs than they reimburse pharmacies, and retain a substantial share of manufacturer rebates, rather than passing those savings on to consumers. Several states, including Ohio and West Virginia, have implemented reforms such as eliminating spread pricing in Medicaid programs, resulting in hundreds of millions of dollars in savings.

[2] Ibid.
[3] U.S. House of Representatives, Committee on Oversight and Accountability. (2024, July 23). *The role of pharmacy benefit managers in prescription drug markets*. https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf

Additionally, drug shortages have become an increasingly pressing issue, affecting both hospitals and retail pharmacies. In Connecticut, 27% of hospitals reported shortages of essential medications, including doxorubicin liposomal (used in cancer treatment) and injectable opioids for pain management. Nationally, the FDA has identified 98 ongoing drug shortages (at the time of publication), many linked to manufacturing disruptions, supply chain inefficiencies, and reliance on limited suppliers. These shortages lead to treatment delays, medication rationing, and increased healthcare costs, disproportionately affecting vulnerable populations and patients in need of critical therapies. Addressing these shortages requires strategic investments in domestic pharmaceutical production, improved supply chain monitoring, and policy measures that encourage diversification of drug sourcing.

Policy discussions have also focused on bulk purchasing initiatives, which allow government agencies and healthcare institutions to negotiate lower drug prices by consolidating purchasing power. Connecticut currently participates in the TOP$ Program, a multi-state bulk purchasing initiative that enables Medicaid programs to leverage collective bargaining strength to obtain supplemental rebates. However, Connecticut has yet to fully utilize bulk purchasing for state agencies beyond Medicaid, such as corrections and public employee health plans.

In addition to bulk purchasing, cost containment strategies like prior authorization and step therapy play a significant role in controlling prescription drug costs. Prior authorization requires healthcare providers to obtain approval before prescribing certain medications, ensuring that treatments align with insurer guidelines. Step therapy, often referred to as "fail first" policies, mandates that patients try lower-cost or insurer-preferred alternatives before accessing more expensive medications. While these measures aim to reduce unnecessary spending, they frequently create delays and administrative burdens, particularly for individuals with chronic conditions who require uninterrupted access to essential medications. To address these concerns, several states have implemented reforms to standardize and streamline these processes, balancing cost control with timely patient care.

Prescription drug spending in the United States has increased steadily, driven by factors such as opaque pricing models, PBM practices, and supply chain disruptions. These issues have led to concerns about affordability, particularly for individuals with chronic conditions who rely on life-sustaining medications.

Key Statistics

- **Prescription Drug Spending** – Nationwide, prescription drug expenditures increased by nearly 16% between 2016 and 2021, primarily due to rising prices rather than increased

utilization.[4] The average annual cost of brand-name prescription drugs increased by 159% during this period, outpacing inflation.[5]

- **PBM Market Control** – The three largest PBMs (CVS Caremark, Express Scripts, and OptumRx) control nearly 79% of the market, creating concerns about market consolidation, limited competition, and price manipulation. Their role in determining which drugs are covered and the rebates negotiated with manufacturers directly impacts consumer costs.[6]
- **Drug Shortages** – The FDA currently tracks 98 ongoing drug shortages (at time of publication), affecting critical medications for cancer, diabetes, and pain management. The average duration of shortages has also increased, lasting over a year in some cases, which delays treatment and contributes to rising healthcare costs.[7]
- **State Pharmaceutical Spending** – Connecticut's Medicaid program spent $10 million on new prescriptions in 2022, with an additional $2.3 million allocated for drug-related repairs and adjustments. This reflects the increasing financial burden of prescription drug coverage on the state's budget.
- **Cost Savings Potential** – Ohio's transition to a delinked PBM fee model, which eliminated spread pricing and implemented a transparent, pass-through pricing structure, saved its Medicaid program over $200 million annually. [8,9]

Meeting Schedule

The Prescription Drug Task Force conducted a series of meetings between December 2024 and February 2025, covering various aspects of prescription drug pricing, affordability, and regulatory frameworks. Below is a list of all full committee and subcommittee meetings, along with key presentations and topics discussed.

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[4] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2023). *Trends in prescription drug spending, 2016-2021.* https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf

[5] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2022). *Trends in prescription drug spending, 2016-2021.* https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf

[6] Fein, A. J. (2024). *The 2024 economic report on U.S. pharmacies and pharmacy benefit managers* (Chapter 5). Drug Channels Institute.

[7] U.S. Food and Drug Administration, Center for Drug Evaluation and Research and FDA's Center for Biologics Evaluation and Research. (2023). Report to Congress: Drug Shortages CY 2023. https://www.fda.gov/media/179156/download

[8] Ohio Auditor of State. (2018, August 16). *Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period*. https://ohioauditor.gov/news/pressreleases/details/5042

[9] Meyer, H. (2019, October 1). *Ohio to save $240M in Medicaid drug costs by running its own PBM*. Modern Healthcare. https://www.modernhealthcare.com/medicaid/ohio-save-240m-medicaid-drug-costs-running-its-own-pbm

For complete copies of all agendas, presentations, distributed materials, and resources shared during each meeting, please visit the task force website at: http://cga.ct.gov/hs/taskforce.asp?TF=20241204_Prescription%20Drug%20Task%20Force

Full Committee Meetings

- December 4, 2024 – Inaugural meeting outlining task force objectives and committee structure.
    - Agenda: Introductions, Logistics, Task Force Goals and Timeline
    - Materials: Prescription Drug Task Force meeting calendar
- February 26, 2025 – Final meeting of the task force
    - Agenda: Discussion of final report recommendations
    - Materials: Final report

Subcommittee Meetings

PBM Oversight

- December 16, 2024 – PBM industry practices and oversight.
    - Agenda: Presentation by the National Academy for State Health Policy (NASHP), Discussion on Transparency, Discussion on Market Structure Effect on Costs
    - Materials: NASHP Presentation
- January 7, 2025 – PBMs in Connecticut.
    - Agenda: Presentation by the Office of Health Strategy (OHS), Discussion
    - Materials: OHS Report Presentation on PBMs, OLR Report on PBM Laws in Connecticut
- February 11, 2025 – Discussion on Policy Proposals (Joint with Importation, Shortages, and Pharmacy Subcommittee).

Pricing & 340B

- December 19, 2024 – Transparency in 340B pricing and insurer-owned specialty pharmacies.
    - Agenda: Presentation by the NASHP on Prescription Drug Advisory Boards and Reference Pricing, OHS Presentation on 340B Program, Discussion on Transparency, Discussion on State Purchasing
    - Materials: NASHP Presentation, OHS Presentation
- January 8, 2025 – Further discussion on 340B
    - Agenda: NASHP Presentation on 340B, Discussion on 340B
    - Materials: NASHP Presentation
- February 13, 2025 – Discussion on Policy Proposals (Joint with Patient Protection, Rare Disease, and Innovation Subcommittee).

Patient Protection, Rare Diseases, & Innovation

- December 17, 2024 – Challenges in transparency and cost containment.
    - Agenda: Discussion on Transparency, Discussion on Step Therapy and Prior Authorization
- January 14, 2025 – Stakeholder input and policy refinement.
    - Agenda: Discussion on Step Therapy and Prior Authorization
- February 13, 2025 – Discussion on Policy Proposals (Joint with Pricing and 340B Subcommittee)

Importation, Shortages, and Pharmacy

- December 18, 2024 – Addressing pharmaceutical shortages and international importation feasibility.
    - Agenda: American Pharmacists Association (APhA) Presentation on Drug Shortages, Discussion on Shortages and Drug Ingredients At-Risk of Shortage, Discussion on the Effect of Tariffs on Drug Availability, Discussion on Importation
    - Materials: APhA Presentation
- January 15, 2025 – Innovations in Manufacturing to Address Shortages
    - Agenda: Presentation by DIANT Pharma, Discussion on the Resilience of Pharmacies
- February 11, 2025 – Discussion on Policy Proposals (Joint with PBM Oversight Subcommittee)

Consensus Recommendations

Pharmaceutical cost inflation remains a pressing issue in the United States, exacerbating disparities in healthcare access and affordability. Three key policy areas require urgent attention: the role of Pharmacy Benefit Managers (PBMs) in drug pricing, opportunities for international importation to enhance drug affordability, and the need to address supply chain issues leading to drug shortages, especially in emergency situations. This document synthesizes multiple sources of information – including task force discussions, extensive research, and state-level data – to provide targeted recommendations for reform.

Pharmacy Benefit Manager Compensation

Fiduciary Duty

PBMs act as intermediaries between drug manufacturers, insurance providers, and pharmacies, negotiating rebates and setting reimbursement rates. While PBMs do not directly set the price of medications, they do determine the reimbursement to pharmacists and their dominant position

within the market heavily influences the final cost to consumers. Despite their pivotal role in prescription drug distribution, PBMs are not currently required to act in the best financial interests of patients and plan sponsors. Instead, PBMs retain substantial rebates and negotiate complex pricing schemes that prioritize their own profits over affordability.

Designating PBMs as fiduciaries would impose legal obligations requiring them to prioritize cost control over profit maximization. This would prevent self-dealing, force disclosure of pricing structures, and create pathways for enforcement against PBMs engaging in anti-competitive practices.

Maine has already implemented fiduciary requirements for PBMs, compelling them to operate transparently and in alignment with the financial interests of insurers and consumers. New Jersey has extended these protections to pharmacies as well. Similar efforts are being considered in New York and other states, reflecting a growing movement toward regulatory accountability.

Policy Actions:

- Classify PBMs as fiduciaries, requiring them to prioritize the financial interests of plan sponsors.
- Mandate disclosure to plan sponsor of any relationship, arrangement, agreement, policy, practice, procedure, or activity that presents a conflict of interest.

Delinking PBM Compensation from Drug Prices

A significant portion of PBM compensation is tied to the size of the discount (or reimbursement) they negotiate for their plan sponsors This creates a market structure that favors high list prices and large rebates rather than the lowest price a manufacturer is willing to offer. Insurers reap the benefit of these rebates while the discount ultimately is not passed on to consumers. In fact, this rebate structure typically increases the cost burden on consumers as list prices frequently determine the size of a patient's cost share, and those without insurance are forced to pay the list price at the pharmacy counter. This is especially problematic in a highly vertically integrated market.

A delinked administrative fee model would reform PBM compensation by shifting away from revenue structures that provide a perverse incentive to increase to drug prices. Instead, PBMs would receive flat service fees based on the volume of prescriptions processed, eliminating the financial motivation to favor high-cost drugs and ensuring that savings are passed on to consumers.

Policy Actions:

- Require PBMs to transition to fee-based models that compensate them for administrative services rather than via rebate value.
- Prohibit PBMs from utilizing pricing schemes that incentivize high-cost drug selection over lower-cost alternatives.

- Implement rebate pass-through requirements, mandating that PBMs transfer negotiated savings directly to insurers and consumers.

Banning Spread Pricing

PBMs frequently engage in spread pricing, a practice in which they charge insurers a higher price for drugs than they reimburse pharmacies, creating artificial price inflation. This happens in addition to profit generated via pricing differentials, rebates, and fee assessments negotiated between PBMs and manufacturers. Such a misaligned incentive structure contributes to rising costs without necessarily improving access to lower-cost medications. It also leads to situations where smaller chain and independent pharmacies are forced to fill prescriptions at a loss when they are unable to negotiate the same special bulk pricing available to some of the large vertically integrated and affiliated pharmacies.

Ohio and West Virginia have successfully implemented models in their Medicaid programs that ban this type of spread pricing, leading to savings exceeding $200 million in Ohio alone.[10,11,12] Similar models have been proposed in Arkansas and Louisiana, with Arkansas state audits demonstrating cost reductions and increased pricing transparency.[13,14]

Policy Actions:

- Strengthen regulatory oversight and penalties for PBMs engaging in spread pricing schemes.
- Require that pharmacies are reimbursed at a rate based on either the Wholesale Acquisition Cost (WAC) or National Average Drug Wholesale Acquisition Cost (NADAC) plus a fee to ensure they are not filling prescriptions at a loss.

Transparency in Pricing for Integrated Systems

Vertical integration in the healthcare economy, particularly between insurers, PBMs, and pharmacies, is becoming a greater regulatory concern across the country. These types of relationships obscure incentive structures and allow companies to exert greater control over

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[10] Arkansas Legislative Council. (2020, December 16). *Drug pricing report: Medicaid managed care reform*. Arkansas State Legislature. https://arkleg.state.ar.us/Home/FTPDocument?path=%2FAssembly%2FMeeting+Attachments%2F490%2F3667%2FHandout+1+Drug+Pricing+Vinson+APA+12.16.20.pdf

[11] Ohio Auditor of State. (2018, August 16). *Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period*. https://ohioauditor.gov/news/pressreleases/details/5042

[12] Meyer, H. (2019, October 1). *Ohio to save $240M in Medicaid drug costs by running its own PBM*. Modern Healthcare. https://www.modernhealthcare.com/medicaid/ohio-save-240m-medicaid-drug-costs-running-its-own-pbm

[13] U.S. Government Accountability Office. (2022, November). *Prescription drugs: Selected states' regulation of pharmacy benefit managers*. https://www.gao.gov/assets/d24106898.pdf

[14] Arkansas Legislative Council. (2020, December 16). *Drug pricing report: Medicaid managed care reform*. Arkansas State Legislature. https://arkleg.state.ar.us/Home/FTPDocument?path=%2FAssembly%2FMeeting+Attachments%2F490%2F3667%2FHandout+1+Drug+Pricing+Vinson+APA+12.16.20.pdf

patient access, sites of care, covered services, and pricing. For example, a recent report by *Drug Channels* found that 62% of OptumRx's business came from affiliated companies under UnitedHealthcare Group's umbrella, and $49 billion of CVSHealth's revenue reflected transactions between their pharmacy and healthcare services segments.[15] These arrangements enhance parent companies' profits while stifling competition, ultimately costing consumers more at the pharmacy counter.

Policy Actions:

- Require disclosing to state regulators information about pricing offered to and profit generated between affiliated insurers, PBMs, and mail-order pharmacies.

International Drug Importation

The Section 804 Importation Program (SIP) allows states to import prescription drugs from Canada at lower prices, provided they meet the same FDA safety requirements applied to all drugs produced in the United States. While Florida has recently received FDA approval to proceed with a drug importation program, Connecticut has not yet moved to develop a SIP proposal.

Consistent with the expansion of supply in any market, drug importation from Canada has the potential to reduce medication costs for Connecticut residents, particularly for high-cost chronic disease medications. Canadian manufacturers already produce many of the medications available in the United States to the same or better safety standards and at a fraction of the cost.

While the task force heard from several members that an importation program is not viable given statements by the Canadian government expressing their lack of interest in exporting drugs, the chairs note that market expansions generally require preceding demand signals.

Even if a program were not immediately implemented, providing a legal and regulatory framework now would only benefit the state when conditions become ripe to do so. It is in the best interests of the people of Connecticut to add their 3.7 million voices to the demand for cheaper Canadian drugs and for their state government to be prepared for international importation as soon as that market opens.

Policy Actions:

- Direct the Connecticut Department of Consumer Protection (DCP) to assess the feasibility of submitting an SIP proposal.
- If viable, file a formal SIP proposal with the FDA (adhering to Section 804 regulatory requirements) and begin any necessary processes to promulgate rules and propose legislation necessary to implement and administer such a program.

[15] Fein, A. J. (2024, May 7). *Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: A May 2024 Update*. Drug Channels Institute. https://www.drugchannels.net/2024/05/mapping-vertical-integration-of.html

- Explore alternative importation pathways, such as establishing direct agreements with Canadian pharmaceutical suppliers.

Emergency Preparedness and Drug Shortage Mitigation

Drug shortages remain a persistent challenge, leading to disruptions in care for critical medications including chemotherapy agents, epinephrine, and opioid analgesics. Connecticut hospitals report ongoing shortages, with 27% of hospitals identifying gaps in medication supply.

Expanding the Strategic Supply Chain Initiative (SSCI) and other relevant executive branch programs and proposals to explicitly include pharmaceutical manufacturers and distributors would help address supply vulnerabilities. Additionally, multi-state bulk purchasing agreements can enhance supply chain stability while driving down costs.

Policy Actions:

- Expand SSCI and executive branch funding to explicitly support pharmaceutical production and distribution as a priority area.
- Explore partnerships between the state, hospitals, Native American tribes, and manufacturers to develop reliable sourcing for critical generic drugs.

Prior Authorization and Step Therapy Reform

The most expensive drug is the one not taken properly. This includes situations where less effective medications or those with higher compliance burdens are substituted for a physician's preferred treatment because they have a higher rebate; and where patients do not take their prescription at all because they know from previous experience that the medication will not work for them and are only waiting to get to a higher step on their cost containment plan. It also encompasses circumstances where a patient's condition becomes ever more acute – and, thus, costly to treat – while they wait for approval for access to medicine their doctor has already determined will benefit them.

Prior authorization and step therapy requirements create significant delays in patient access to necessary medications. These administrative barriers force patients to retry ineffective protocols and delay treatments before accessing more appropriate therapies, resulting in worsened health outcomes, increased long-term costs, and squandered funds.

When changing jobs, or when their employer changes health plans, employees with chronic conditions often face repetitious, unnecessary bureaucracy to gain back access to their medications. An insulin-dependent diabetic will always need insulin to survive. The same is true for many other conditions. The added burden of reconfirming this fact only increases administrative costs, driving up healthcare inflation. Given that government funds are used to subsidize much of this spending, the task force chairs see this as an important issue to address.

Standardizing prior authorization and step therapy requirements across all insurers and establishing portability would ensure that patients retain medication approvals even when switching health plans. These reforms have been successfully implemented in various states to reduce unnecessary delays and administrative burdens.

Policy Actions:

- Standardize prior authorization and step therapy criteria across all Connecticut insurers to eliminate unnecessary variations in approval processes.
- Implement portability regulations, ensuring that patients who have already completed prior authorization and/or step therapy do not need to repeat failed treatments under a new insurer.
- Increase public transparency regarding insurance formularies and approval timelines.

Overview of Additional Policy Items Considered

This section provides an analysis of various policy proposals considered by the task force that the chairs found had merit but ultimately decided against including in their consensus recommendations. It encompasses initiatives focused on pricing requirements, prescription drug affordability boards, transparency, regulatory oversight, and purchasing strategies.

Reference Pricing

Reference pricing sets a benchmark price for medications, using a comparative approach based on international or domestic drug pricing models. This methodology ensures that prescription drugs are priced according to their value relative to similar therapies. While some states have explored reference pricing as a cost containment strategy, concerns remain over implementation logistics and legal challenges.

In particular, the Inflation Reduction Act (IRA) introduced new pricing negotiation mechanisms for Medicare, particularly targeting high-cost drugs. The federal government's ability to negotiate prices directly with manufacturers is expected to reduce drug costs for Medicare beneficiaries, but the full impact remains uncertain. Some state-level discussions have considered aligning public employee health plans with IRA-negotiated prices or leveraging Medicare's new framework for additional cost-saving initiatives. The integration of IRA pricing principles into state purchasing policies remains under debate.

Prescription Drug Affordability Board with Upper Payment Limits

Prescription Drug Affordability Boards (PDABs) establish state-level oversight of high-cost drugs, setting upper payment limits to ensure affordability. PDABs are often combined with an Upper Payment Limit (UPL), which defines the maximum reimbursement rate above which purchasers throughout the state may not pay for prescription drug products. Several states,

including Maryland and Colorado, have implemented PDABs, with some success in controlling excessive pricing. Connecticut has debated establishing a PDAB with authority to cap payments for the most expensive drugs but concerns about implementation have stalled progress.

March-In Rights for GLP-1 Drugs

March-in rights allow the federal government to intervene when taxpayer-funded research contributes to the development of a patented item but it remains inaccessible to the public. Some policymakers see high prescription drug prices as an accessibility issue and are urging federal action to use march-in rights for GLP-1 medications developed with federal funds, which are commonly prescribed for diabetes and weight management. If successful, this could compel manufacturers to lower prices or allow third-party production. However, the federal government has historically been reluctant to exercise these rights and industry opposition remains strong.

Transparency and Regulatory Oversight

Broader PBM Transparency

PBMs operate with significant opacity, often engaging in practices such as spread pricing, rebate retention, and patient steering. Calls for greater PBM transparency include requiring detailed disclosures on pricing methodologies, rebate structures, and contracts with insurers and pharmacies. Some states have implemented mandates for PBMs to report transaction details to state regulatory bodies, but federal action remains limited.

340B

Benefit to Hospitals

Hospitals participating in the 340B Drug Pricing Program benefit from significant discounts on outpatient drugs, yet there is limited reporting on how these savings are utilized. Research suggests that disproportionate share hospitals (DSHs) use 340B savings to improve margins rather than directly subsidizing patient care.[16,17] Legislative proposals focus on requiring hospitals to disclose how 340B savings contribute to patient affordability and community benefit. Some states have proposed mandatory reporting on how hospitals allocate 340B funds, such as Maine's LD 1995, which requires annual disclosures on the use of 340B savings for community services.

Contract Pharmacies

Increasingly, manufacturers are limiting the number and location of contract pharmacies utilized by 340B covered entities to deliver medications to their clients. This is particularly difficult in situations where these entities have multiple locations and are restricted to only one pharmacy or

[16] Levengood, T. (2024, January). *Assessing the Impact of the 340B Drug Pricing Program: A Scoping Review of the Empirical, Peer-Reviewed Literature*. https://doi.org/10.1111/1468-0009.12691
[17] Nikpay, Sayeh. (2020, April). *Relationship between initiation of 340B participation and hospital safety-net engagement*. Health Services Research. https://doi.org/10.1111/1475-6773.13278.

utilize a mail order service for specialty and maintenance drugs. The pharmaceutical industry alleges this is necessary to control proliferation of the 340B program beyond its intended use. Legislative proposals in other states have focused on prohibiting discrimination against contract pharmacies and other restrictions on how covered entities may dispense prescriptions.

Pay-for-Delay and Contract Disclosure

Pay-for-delay agreements, in which brand-name drug manufacturers compensate generic manufacturers to delay market entry, keep drug prices artificially high. Connecticut has considered requiring pharmaceutical companies to disclose such agreements to the Office of Health Strategy (OHS) to enhance regulatory oversight.

Bulk Purchasing

Bulk Purchasing Among State Agencies

Consolidating state agency drug purchases can increase negotiating power and drive down costs. Within Connecticut, the state health plan, the Department of Corrections, and UConn Health account for the vast majority of public-sector pharmaceutical spending. Efforts to coordinate purchasing between these entities have been explored but face administrative hurdles.

One proposal would expand the comptroller's ability to purchase drugs through the 340B program, which could reduce costs for public employee health plans. This initiative remains under discussion, particularly regarding whether it would violate 340B program rules on eligibility and distribution.

Larger Pool Within the State

Creating a larger state-level purchasing pool by combining Medicaid, state employee health plans, other public health programs with private sector participation could enhance price negotiations. However, logistical challenges, including regulatory approval and pricing variability across programs, complicate implementation.

Additional Items

The following items were brought up at task force meetings but only briefly discussed.

Application of certain payments toward deductibles.

Contained in HB-6870, the Governor's proposal would require all patient assistance and third-party payments to count toward insurance deductibles. Insurers and PBMs opposed this measure, arguing it would undermine cost-sharing incentives.

Prohibition on generic drug price increases beyond inflation.

Similar to a PDAB/UPL, the Governor's proposal from HB-6870 seeks to curb unsupported price increases. However, it utilizes a civil penalty rather than a payment limit.

Acquisition cost pricing for PBM-owned mail-order and specialty pharmacies.

This measure sought to ensure fair pricing by requiring acquisition cost transparency, but it overlaps with spread pricing legislation and was deemed redundant.

Applying 340B pricing to cash payments.

This initiative aimed to extend 340B discounts to uninsured cash-paying patients, but legal barriers have prevented its advancement.

White/Brown Bagging Regulations.

White bagging (requiring specialty medications to be dispensed through PBM-owned pharmacies) and brown bagging (requiring patients to transport specialty medications to their providers) remain contentious, with no consensus on regulation.

Drug Availability Data.

A proposal to mandate real-time reporting on drug shortages and availability did not gain traction due to concerns over implementation costs and whether similar information already exists.

Anti-Price Gouging Laws

Task force members considered strengthening anti-price gouging protections for essential medications, but enforcement complexities led to the proposal being tabled.

Three-Month Supply Requirement

A proposal requiring insurers to cover a three-month supply of maintenance medications stalled due to concerns over supply chain disruptions.

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