

Report of the Working Group to Study Pharmacist Compensation Pursuant to Public Act 25-167

I. Introduction and Legislative Background

Public Act 25-167 established the Working Group to Study Pharmacist Compensation in recognition of the expanding clinical role pharmacists play in Connecticut's health care delivery system. The Act directed the convening of a multi-stakeholder working group to examine whether and how pharmacists licensed under Chapter 400j should be compensated for specified health care services already authorized under state law, including vaccine administration, HIV-related testing and treatment, influenza-related testing, and prescribing FDA-approved contraceptive products.

The charge to the working group was to evaluate existing barriers, review national experience, and develop findings and recommendations for legislative consideration. The Act reflects a broader national trend toward leveraging pharmacists as accessible health care providers to improve access to preventive and primary care services, reduce delays in care, and relieve system capacity constraints—without expanding scope of practice or increasing costs to consumers.

II. Composition and Process

The working group consisted of representatives of legislative leadership, relevant state agencies, pharmacists from diverse practice settings, employers, insurers, pharmacy benefit managers, academia, and the state health insurance exchange. Meetings were conducted over multiple months and included presentations, stakeholder testimony, comparative state research, and extensive discussion regarding policy design, implementation feasibility, and cost impacts.

The group's deliberations emphasized consensus-building and were guided by legislative intent to pursue access-oriented reforms while avoiding unintended fiscal or administrative consequences.

III. Key Findings and Discussion Themes

A. Role of Pharmacists in Care Delivery

The working group heard consistent testimony that pharmacists already provide a wide range of clinical services authorized under existing law, extending well beyond medication dispensing. These services include immunizations, point-of-care testing, medication management, patient counseling, and coordination with other licensed providers.

Pharmacists are often among the most accessible health care professionals, particularly in community settings where primary care access may be limited.

Despite this role, pharmacists generally lack a viable pathway to participate in insurer provider networks or to bill for covered clinical services in the same manner as other licensed providers, even when the services are otherwise covered by the health plan.

B. Reimbursement Infrastructure and National Experience

At the national level, pharmacist-provided services are typically billed using existing medical billing codes, including established CPT codes for immunization administration and clinical testing. Reimbursement, where permitted, is generally paid to the employing entity rather than to individual practitioners, using the same credentialing, compliance, and claims processes applied to other providers.

Other states that have adopted pharmacist reimbursement frameworks report that implementation challenges mirror routine medical billing issues and are not unique to pharmacists. No evidence was presented of systemic cost increases attributable solely to pharmacist participation. Instead, states report improved access to preventive services and earlier intervention.

IV. Policy Approaches Considered

The working group evaluated two conceptual legislative approaches:

- Proposal #1 would prohibit insurers, third-party administrators, or pharmacy benefit managers from denying reimbursement for pharmacist-provided services that are otherwise covered when performed by other licensed providers. While framed as parity, this approach was widely viewed as functioning as a reimbursement mandate due to its “may not deny” construction.
- Proposal #2 would require health plans to ensure that reimbursement processes and provider networks are inclusive of licensed pharmacists for covered clinical services, while preserving insurer discretion regarding contracting, credentialing, rates, and medical necessity. This approach establishes a pathway to participation without mandating coverage or payment.

While both proposals share the same policy objective—improving access to pharmacist-provided services—the working group consistently distinguished between mandating reimbursement and enabling participation.

V. Guiding Principles

Through its deliberations, the working group coalesced around the following guiding principles:

1. **No Mandate:** Any legislative action should not impose a reimbursement mandate on insurers, third-party administrators, or pharmacy benefit managers.
2. **No Added Cost to Consumers:** Reforms should not increase premiums, cost-sharing, or prescription costs for consumers. Pharmacist participation should function as substitution of site of service—not an additive benefit.
3. **No Change to Scope of Practice:** The working group does not recommend any expansion of pharmacists’ scope of practice. All services contemplated are already authorized under existing law.
4. **Preservation of Existing Contracting and Credentialing Authority:** Payers should retain discretion over contracting terms, credentialing standards, reimbursement rates, network participation, utilization management, and claims adjudication, consistent with how they operate for other provider types.

VI. Recommendation

The working group supports advancing Proposal #2 as the preferred policy framework, subject to refinement of statutory language to clearly reflect the guiding principles above.

VII. Implementation Considerations and Effective Date

A consistent theme of the working group’s discussions was that implementation cannot be assumed to occur automatically upon passage of statutory language. Credentialing processes, network configuration, claims systems, coding practices, and plan design cycles all require lead time and coordination—particularly for exchange-based plans, self-insured arrangements, and public programs.

Accordingly, the working group recommends that any legislation adopted pursuant to Proposal #2 have an effective date of January 1, 2028. This timeline would:

- Allow sufficient time for regulatory review and statutory alignment;
- Enable insurers and administrators to incorporate changes into annual plan design and rate-filing cycles;
- Provide an opportunity for coordination with the state health insurance exchange, other third party administrators, and the state employee health plan;
- Reduce the risk of consumer confusion or operational disruption during a period of significant change in the broader health insurance landscape.

VIII. Conclusion

Public Act 25-167 provided a structured forum for thoughtful examination of pharmacist compensation in the context of evolving health care delivery. The working group's discussions reflect broad support for improving access to pharmacist-provided services while maintaining insurer flexibility, fiscal discipline, and administrative feasibility.

By advancing a non-mandated, process-oriented approach with an appropriate implementation timeline, the General Assembly can create a pathway for pharmacist participation that strengthens access to care without increasing costs to consumers or disrupting existing insurance markets. Any final policy determinations will appropriately rest with the General Assembly following further review and refinement during the legislative process.

Members

Representative Kerry Wood

Representative Cara Pavalock-D'Amato

Michelle Pope, Insurance Associate Examiner, Life & Health Division

Troy Ruff, Principal Drug Control Agent

Todd DeGroff, Owner of Beacon Pharmacy in New Britain

Julian Koruni, PharmD

Osama Abdelghany, PharmD, MHA, BCOP

Sam Hallemeier, PCMA

Marie Smith, PharmD, FNAP, Assistant Dean/ Henry A. Palmer Professor, UConn School of Pharmacy

Tim Phelan, President, CT Retail Network

Paul Pescatello, Bioscience Growth Council, CBIA

Kelly Cote, Plan Management Manager with Access Health CT

Matthew Murphy, PharmD, BCOP, Clinical Pharmacy Specialist, Oncology, Baystate Medical Center

Ed Schreiner, Jr., Vice President of Network Development, Northeast Pharmacy Service Corporation