General Assembly

Raised Bill No. 5384

February Session, 2018

LCO No. **1929**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING PRESCRIPTION DRUG COSTS.

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

Section 1. (NEW) (*Effective January 1, 2019*) (a) For the purposes of this section:

(1) "Aggregate retained rebate percentage" means the following, expressed as a percentage and calculated on an annual basis for each covered prescription drug for which a pharmacy benefits manager received a rebate under a particular health benefit plan:

(A) All rebates that the pharmacy benefits manager received, excluding any portion of such rebates received by the health carrier that delivered, issued for delivery, renewed, amended or continued the health benefit plan that covered such prescription drug;

(B) Divided by all rebates that the pharmacy benefits manager received related to use of the covered prescription drug, including any portion of such rebates received by such health carrier.

(2) "Drug" has the same meaning as provided in section 21a-92 of

the general statutes.

(3) "Health benefit plan" means a health benefit plan, as defined in section 38a-591a of the general statutes, that includes prescription drug coverage.

(4) "Health carrier" has the same meaning as provided in section 38a-591a of the general statutes.

(5) "Pharmacy" has the same meaning as provided in section 38a-479aaa of the general statutes.

(6) "Pharmacy benefits manager" or "manager" has the same meaning as provided in section 38a-479aaa of the general statutes.

(7) "Prescription drug" means any drug prescribed by a health care provider to an individual in this state.

(8) "Rebate" means any discount or concession, including any volume-based discount or concession, regarding the price of a prescription drug that a pharmaceutical manufacturer provides, directly or indirectly, to a pharmacy benefits manager after the pharmacy benefits manager processes a claim from a pharmacy for a prescription drug manufactured by such pharmaceutical manufacturer.

(b) Not later than March 1, 2019, and annually thereafter, each pharmacy benefits manager shall file a report with the Insurance Commissioner. The report shall contain the following information, for the immediately preceding calendar year, for each health benefit plan that included a pharmacy benefit managed by the pharmacy benefits manager:

(1) The total dollar amount of all rebates that such pharmacy benefits manager received from pharmaceutical manufacturers;

(2) The total dollar amount of all rebates that such pharmacy benefits manager received from pharmaceutical manufacturers,

excluding any portion of such rebates received by a health carrier;

(3) The total dollar amount of all administrative fees that such pharmacy benefits manager received from the health carrier that delivered, issued for delivery, renewed, amended or continued the health benefit plan; and

(4) The highest, lowest and mean aggregate retained rebate percentage.

(c) (1) The Insurance Commissioner shall post, in a timely manner, the information the commissioner receives pursuant to subsection (b) of this section on the Insurance Department's Internet web site.

(2) Notwithstanding subdivision (1) of this subsection, the commissioner shall not disclose any information the commissioner receives pursuant to subsection (b) of this section if such information would enable a third party to identify a particular health carrier or health benefit plan, the prices charged for any particular drug or therapeutic class of drugs, or the value of any rebates provided for any particular drug or therapeutic class of drugs. The information described in this subdivision shall not be available for public inspection, and the office shall withhold such information and data from public disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes.

(d) Each pharmacy benefits manager shall, for each health benefit plan that includes a pharmacy benefit managed by the pharmacy benefits manager, publish on its Internet web site (1) the drug formulary, and (2) timely notice regarding any (A) change to such drug formulary, or (B) exclusion from such drug formulary.

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

Sec. 2. (NEW) (*Effective January 1, 2019*) (a) Each insurer, health care center, hospital service corporation, medical service corporation or

fraternal benefit society that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy in this state on or after January 1, 2019, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall, on or before May 1, 2019, and annually thereafter, submit a report to the Insurance Commissioner containing statistical information for the preceding calendar year, including, but not limited to, information concerning:

(1) Complaints regarding health care providers and quality of care, including the ratio of the number of complaints received to the total number of individuals insured;

(2) Decisions on requests for coverage of noncovered benefits; and

(3) Prior authorizations, including, but not limited to, (A) the ratio of the number of prior authorizations denied to the number of prior authorizations requested, (B) for each level of review, the number of prior authorization appeals denied to the total number of prior authorization appeals conducted, and (C) the maximum, minimum and average number of hours that passed between submission of a request for prior authorization and entry of a decision regarding such request, including any internal or external appeals from such decision.

(b) Each report submitted pursuant to subsection (a) of this section shall be in a format that permits comparison between health insurance policies.

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

Sec. 3. (NEW) (*Effective January 1, 2019*) (a) For purposes of this section:

(1) "Drug" has the same meaning as provided in section 21a-92 of the general statutes;

(2) "Health benefit plan" means a health benefit plan, as defined in

section 38a-591a of the general statutes, that includes prescription drug coverage;

(3) "Health carrier" has the same meaning as provided in section 38a-591a of the general statutes;

(4) "Prescription drug" means any drug prescribed by a health care provider to an individual in this state;

(5) "Rebate" means any rebate, discount or other price concession that the state or a health carrier receives or expects to receive, directly or indirectly, from a pharmaceutical manufacturer relating to the use of a prescription drug manufactured by the pharmaceutical manufacturer;

(6) "Research and development cost" means any cost that a pharmaceutical manufacturer incurs during a calendar year in researching or developing a new product, process or service, including, but not limited to, any cost that a pharmaceutical manufacturer incurs in researching or developing a product, process or service that the pharmaceutical manufacturer has acquired from another person by license; and

(7) "Wholesale acquisition cost" has the same meaning as provided in 42 USC 1395w-3a.

(b) (1) Beginning on March 1, 2019, and annually thereafter, a health carrier may submit a written complaint to the Insurance Commissioner, in a form and manner prescribed by the commissioner, regarding a prescription drug if:

(A) The health carrier delivered, issued for delivery, renewed, amended or continued a health benefit plan in this state during the immediately preceding calendar year;

(B) The health carrier included the prescription drug in the health benefit plan's drug formulary;

(C) The wholesale acquisition cost of the prescription drug increased by not less than twenty-five per cent during the immediately preceding calendar year; and

(D) The health carrier determines, through an actuarial analysis performed by an independent, third-party actuary, (i) that the increase in the wholesale acquisition cost of the prescription drug, less all rebates paid to the health carrier during the immediately preceding calendar year for the prescription drug and controlling for all other changes in expenses and costs incurred under the terms of the health benefit plan, caused the premium of the health benefit plan to increase by not less than one dollar per member per month, (ii) the dollar amount of such increase, and (iii) the dollar amount of such increase attributable to increased utilization of the prescription drug.

(2) Each health carrier that submits a complaint to the office pursuant to subdivision (1) of this subsection shall simultaneously submit a copy of the complaint to the pharmaceutical manufacturer that manufactured the prescription drug that is the subject of the complaint.

(c) Not later than thirty days after a pharmaceutical manufacturer receives a complaint submitted pursuant to subsection (b) of this section, the pharmaceutical manufacturer shall submit to the commissioner, in a form and manner prescribed by the commissioner, a written response to the complaint. The response shall include information regarding (1) all rebates that the pharmaceutical manufacturer paid, directly or indirectly, to the health carrier during the immediately preceding calendar year for the prescription drug that is the subject of the complaint, and (2) utilization of the prescription drug that is the subject of the complaint under the relevant health benefit plan.

(d) The commissioner shall (1) review each complaint and response submitted pursuant to subsections (b) and (c) of this section, and (2) determine whether the increase in the cost of the prescription drug

caused the increase in the premium of the health benefit plan.

(e) If the commissioner determines, pursuant to subsection (d) of this section, that the increase in the cost of the prescription drug caused the increase in the premium of the health benefit plan, the commissioner shall (1) certify such determination, and (2) issue written notice of such determination, in a form and manner prescribed by the commissioner, to the health carrier and the pharmaceutical manufacturer.

(f) Each pharmaceutical manufacturer of a prescription drug that causes the premium of a health benefit plan to increase by an amount that is not less than the amount described in subparagraph (C) of subdivision (1) of subsection (b) of this section shall submit to the commissioner, in a form and manner prescribed by the commissioner, (1) aggregate, company-level research and development costs and such other capital expenditures that the commissioner, in the commissioner's discretion, deems relevant for the most recent year for which final audited data are available, and (2) a written, narrative description, suitable for public release, of all factors that contributed to the increase in the cost of the prescription drug.

(g) The quality and types of information and data that a pharmaceutical manufacturer submits to the commissioner under this section shall be consistent with the quality and types of information and data that the pharmaceutical manufacturer includes in (1) such pharmaceutical manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K, or (2) any other public disclosure.

(h) The commissioner shall consult with pharmaceutical manufacturers to establish a single, standardized form for reporting information and data pursuant to this section. The form shall minimize the administrative burden and cost imposed on the state and pharmaceutical manufacturers.

(i) Except as otherwise provided in subsection (f) of this subsection,

information and data submitted to the commissioner pursuant to this section shall not be available for public inspection, and the commissioner shall withhold such information and data from public disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes. The commissioner shall not disclose such information and data in a manner that would enable a third party to identify an individual drug, therapeutic class of drugs or pharmaceutical manufacturer, or that is likely to compromise the financial, competitive or proprietary nature of such information and data.

Sec. 4. Section 19a-754a of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) For the purposes of this section:

(1) "Drug" has the same meaning as provided in section 21a-92.

(2) "Exchange" means the Connecticut Health Insurance Exchange, established pursuant to section 38a-1081.

(3) "Health benefit plan" means a health benefit plan, as defined in section 38a-591a, that includes prescription drug coverage.

(4) "Health carrier" has the same meaning as provided in section 38a-591a.

(5) "Office" means the Office of Health Strategy established in subsection (b) of this section.

(6) (A) "Payer" means (i) each department, agency and institution supported, in whole or in part, by the state that provides prescription drugs at state expense, (ii) a health carrier, (iii) an insurer, as described in section 38a-1, or health care center, as defined in section 38a-175, that provides coverage under Part C or Part D of Title XVIII of the Social Security Act, as amended from time to time, to residents of this state, (iv) a third-party administrator, as defined in section 38a-720, (v)

a pharmacy benefits manager, as defined in section 38a-479aaa, (vi) a nonprofit medical service corporation, as defined in section 38a-214, (vii) a dental plan organization, as defined in section 38a-577, (viii) a preferred provider network, as defined in section 38a-479aa, and (ix) any other person who administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments.

(B) "Payer" does not mean an employee welfare benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

(7) "Prescription drug" means any drug prescribed by a health care provider to an individual in this state.

(8) "Rebate" means any rebate, discount or other price concession that the state or a health carrier receives or expects to receive, directly or indirectly, from a pharmaceutical manufacturer relating to the use of a prescription drug manufactured by the pharmaceutical manufacturer.

(9) "Research and development cost" means any cost that a pharmaceutical manufacturer incurs during a calendar year in researching or developing a new product, process or service, including, but not limited to, any cost that a pharmaceutical manufacturer incurs in researching or developing a product, process or service that the pharmaceutical manufacturer has acquired from another person by license.

(10) "Wholesale acquisition cost" has the same meaning as provided in 42 USC 1395w-3a.

[(a)**]** (b) There is established an Office of Health Strategy, which shall be within the Department of Public Health for administrative purposes only. The department head of said office shall be the

executive director of the Office of Health Strategy, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, with the powers and duties therein prescribed.

[(b)**]** (c) (1) On or before July 1, 2018, the **[**Office of Health Strategy**]** office shall be responsible for the following:

[(1)**]** (A) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;

[(2)**]** (B) Directing and overseeing **[**(A)**]** (i) the all-payers claims database program established pursuant to section 19a-755a, and **[**(B)**]** (ii) the State Innovation Model Initiative and related successor initiatives;

[(3)**]** (C) Coordinating the state's health information technology initiatives;

[(4)**]** (D) Directing and overseeing the Office of Health Care Access and all of its duties and responsibilities as set forth in chapter 368z; and

[(5)**]** (E) Convening forums and meetings with state government and external stakeholders, including, but not limited to, the **[**Connecticut Health Insurance Exchange**]** exchange, to discuss health care issues designed to develop effective health care cost and quality strategies.

(2) (A) On or before March 1, 2019, and annually thereafter, the office, in consultation with the Comptroller, the Commissioner of Social Services, Insurance Commissioner and Commissioner of Public Health, shall prepare a list of not more than ten prescription drugs that the office, in the office's discretion, determines are (i) provided at substantial cost to the state, considering the net cost of such drugs, or (ii) critical to public health. The list shall include prescription drugs

from different therapeutic classes of drugs and not less than one generic prescription drug. The office shall not list any prescription drug under this subparagraph unless the wholesale acquisition cost of the prescription drug, less all rebates paid to the state for such pharmaceutical drug during the immediately preceding calendar year, increased by not less than twenty-five per cent during the immediately preceding calendar year.

(B) The pharmaceutical manufacturer of a prescription drug included on a list prepared by the office pursuant to subparagraph (A) of this subdivision shall provide to the office, in a form and manner described by the office, (i) a written, narrative description, suitable for public release, of all factors that caused the increase in the wholesale acquisition cost of the listed prescription drug, and (ii) aggregate, company-level research and development costs and such other capital expenditures that the office, in the office's discretion, deems relevant for the most recent year for which final audited data are available.

(C) Beginning on June 1, 2019, and annually thereafter, the office shall publish a report that includes all information that the office receives pursuant to subparagraph (B) of this subdivision. The office shall post such report and the information described in this subparagraph on the office's Internet web site.

(D) The quality and types of information and data that a pharmaceutical manufacturer submits to the office under this subdivision shall be consistent with the quality and types of information and data that the pharmaceutical manufacturer includes in (i) such pharmaceutical manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K, or (ii) any other public disclosure.

(E) The office shall consult with pharmaceutical manufacturers to establish a single, standardized form for reporting information and data pursuant to this section. The form shall minimize the administrative burden and cost imposed on the state and

pharmaceutical manufacturers.

(F) Except as otherwise provided in this subdivision, information and data submitted to the office pursuant to this subdivision shall not be available for public inspection, and the office shall withhold such information and data from public disclosure under the Freedom of Information Act, as defined in section 1-200. The office shall not disclose such information and data in a manner that would enable a third party to identify an individual drug, therapeutic class of drugs or pharmaceutical manufacturer, or that is likely to compromise the financial, competitive or proprietary nature of such information and data.

[(c)**]** (d) The Office of Health Strategy shall constitute a successor, in accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the functions, powers and duties of the following:

(1) The **[**Connecticut Health Insurance Exchange, established pursuant to section 38a-1081,**]** exchange relating to the administration of the all-payer claims database pursuant to section 19a-755a; and

(2) The Office of the Lieutenant Governor, relating to the (A) development of a chronic disease plan pursuant to section 19a-6q, (B) housing, chairing and staffing of the Health Care Cabinet pursuant to section 19a-725, and (C) (i) appointment of the health information technology officer pursuant to section 19a-755, and (ii) oversight of the duties of such health information technology officer as set forth in sections 17b-59, 17b-59a and 17b-59f.

[(d)**]** (e) Any order or regulation of the entities listed in subdivisions (1) and (2) of subsection **[**(c)**]** (d) of this section that is in force on July 1, 2018, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 5. Subsection (a) of section 38a-477d of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) Each insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues a health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 in this state, shall:

(1) Make available to consumers, in an easily readable, accessible and understandable format, the following information for each such policy: (A) Any coverage exclusions; (B) any restrictions on the use or quantity of a covered benefit, including on prescription drugs or drugs administered in a physician's office or a clinic; (C) a specific description of how prescription drugs are included or excluded from any applicable deductible, including a description of other out-of-pocket expenses that apply to such drugs; **[**and**]** (D) the specific dollar amount of any copayment and the percentage of any coinsurance imposed on each covered benefit, including each covered prescription drug; and (E) information regarding any process available to consumers, and all documents necessary, to seek coverage of a health care service on the grounds that such service is medically necessary;

(2) Make available to consumers a way to determine accurately (A) whether a specific prescription drug is available under such policy's drug formulary; (B) the coinsurance, copayment, deductible or other out-of-pocket expense applicable to such drug; (C) whether such drug is covered when dispensed by a physician or a clinic; (D) whether such drug requires prior authorization or the use of step therapy; (E) whether specific types of health care specialists are in-network; and (F) whether a specific health care provider or hospital is in-network.

Sec. 6. Section 38a-478j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) Each managed care plan that requires a percentage coinsurance payment by the insured shall calculate the insured's coinsurance payment on the lesser of the provider's or vendor's charges for the

goods or services or the amount payable by the managed care organization for such goods or services, except as otherwise required by the laws of a foreign state when applicable to providers, vendors or patients in such foreign state.

(b) (1) For the purposes of this subsection, "rebate" means (A) any price concession received by a managed care organization regarding use of a prescription drug, and (B) any fee or other administrative cost that reduces a managed care organization's prescription drug costs.

(2) Beginning on March 1, 2019, and annually thereafter, each managed care organization shall submit to the commissioner, in a form and manner prescribed by the commissioner, a certification that (A) during the immediately preceding calendar year, the managed care organization made available to each enrollee that purchased a covered prescription drug, at the time that such enrollee purchased the covered prescription drug, the majority of any rebate for such covered prescription drug, and (B) the managed care organization accounted for all rebates in calculating the premium for each managed care plan issued by such managed care organization.

(3) Except as set forth in subdivision (2) of this subsection, neither the commissioner nor any managed care organization that submits a report to the commissioner pursuant to subdivision (2) of this subsection shall publish or otherwise reveal any information regarding the value of any rebate received by such managed care organization. The commissioner shall withhold such information from public disclosure under the Freedom of Information Act, as defined in section 1-200.

(4) Each managed care organization that receives a rebate shall require that each party to a contract delivered, issued for delivery, renewed, amended or continued by such managed care organization on or after January 1, 2019, shall not publish or otherwise reveal any information regarding the value of any rebate received by such managed care organization.

Sec. 7. Section 38a-479bbb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) **[**Except as provided in subsection (d) of this section, no**]** No person shall act as a pharmacy benefits manager in this state without first obtaining a certificate of registration from the commissioner.

(b) Any person seeking a certificate of registration shall apply to the commissioner, in writing, on a form provided by the commissioner. The application form shall state (1) the name, address, official position and professional qualifications of each individual responsible for the conduct of the affairs of the pharmacy benefits manager, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the pharmacy benefits manager, and (2) the name and address of the applicant's agent for service of process in this state.

(c) Each application for a certificate of registration shall be accompanied by (1) a nonrefundable fee of fifty dollars, and (2) evidence of a surety bond in an amount equivalent to ten per cent of one month of claims in this state over a twelve-month average, except that such bond shall not be less than twenty-five thousand dollars or more than one million dollars.

[(d) Any pharmacy benefits manager operating as a line of business or affiliate of a health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society licensed in this state or any affiliate of such health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society shall not be required to obtain a certificate of registration. Such health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society shall notify the commissioner annually, in writing, on a form provided

by the commissioner, that it is affiliated with or operating a business as a pharmacy benefits manager.**]**

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	New section
Sec. 2	*January 1, 2019*	New section
Sec. 3	*January 1, 2019*	New section
Sec. 4	*January 1, 2019*	19a-754a
Sec. 5	*January 1, 2019*	38a-477d(a)
Sec. 6	*January 1, 2019*	38a-478j
Sec. 7	*January 1, 2019*	38a-479bbb

Statement of Purpose:

To impose additional disclosure and reporting requirements on pharmacy benefits managers, health carriers, pharmaceutical manufacturers, the Office of Health Strategy and the Insurance Department concerning prescription drug rebates and the cost of prescription drugs.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]