General Assembly

Substitute Bill No. 5384

February Session, 2018

HB05384INS 032118

AN ACT CONCERNING PRESCRIPTION DRUG COSTS.

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

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 Section 38a-479aaa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

As used in this section and sections 38a-479bbb to 38a-479iii, inclusive, and sections 2 and 3 of this act:

(1) "Commissioner" means the Insurance Commissioner;

(2) "Department" means the Insurance Department;

(3) "Drug" means drug, as defined in section 21a-92;

(4) "Person" means person, as defined in section 38a-1;

(5) "Pharmacist services" includes (A) drug therapy and other patient care services provided by a licensed pharmacist intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, and (B) education or intervention by a licensed pharmacist intended to arrest or slow a disease process;

(6) "Pharmacist" means an individual licensed to practice pharmacy under section 20-590, 20-591, 20-592 or 20-593, and who is thereby recognized as a health care provider by the state of Connecticut;

(7) "Pharmacy" means a place of business where drugs may be sold at retail and for which a pharmacy license has been issued to an applicant pursuant to section 20-594; and

(8) "Pharmacy benefits manager" or "manager" means any person that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health benefit plan on behalf of plan sponsors such as self-insured employers, insurance companies, labor unions and health care centers.

Sec. 2. (NEW) (*Effective January 1, 2019*) (a) As used in this section:

(1) "Health benefit plan" means a health benefit plan, as defined in section 38a-591a of the general statutes, that includes a pharmacy benefit;

(2) "Health carrier" means a health carrier, as defined in section 38a-591a of the general statutes; and

(3) "Rebate" means a discount or concession, including a volume-based discount or concession, which affects the price of a prescription drug, and is provided by a pharmaceutical manufacturer, 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 Office of Health Strategy, established pursuant to section 19a-754a of the general statutes, as amended by this act, for the immediately preceding calendar year. The report shall contain the following information for each health benefit plan that included a pharmacy benefit managed by the pharmacy benefits manager during such calendar year:

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

manufactured drugs covered by such health benefit plan during such calendar year;

(2) The total dollar amount of all rebates that such pharmacy benefits manager received from pharmaceutical manufacturers that manufactured drugs covered by such health benefit plan during such calendar year, excluding any portion of such rebates received by the health carrier that delivered, issued for delivery, renewed, amended or continued such plan; and

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

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

Sec. 3. (NEW) (*Effective January 1, 2019*) (a) Each pharmacy benefits manager shall, for each health benefit plan that includes a pharmacy benefit managed by such pharmacy benefits manager, publish on such pharmacy benefits manager's Internet web site (1) such health benefit plan's drug formulary, and (2) timely notice regarding any (A) change to such formulary, or (B) exclusion from such formulary.

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

Sec. 4. (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 immediately preceding calendar year, including, but not limited to, information concerning:

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

(2) Prior authorizations, including, but not limited to, (A) the ratio of prior authorizations denied to prior authorizations requested, (B) for each level of review, the ratio of prior authorization appeals denied to 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 the Insurance Commissioner to make a comparison between health insurance policies.

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

Sec. 5. (NEW) (*Effective January 1, 2019*) (a) For the 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) "Rebate" means any direct or indirect rebate, discount or other

price concession that the state or a health carrier receives, or expects to receive, from a pharmaceutical manufacturer related to use of a prescription drug manufactured by such pharmaceutical manufacturer;

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

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

(b) (1) Not later than 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 at least 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 such 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 such health benefit plan to increase by at least 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 such prescription drug.

(2) Each health carrier that submits a complaint to the commissioner pursuant to subdivision (1) of this subsection shall simultaneously submit a copy of such complaint to the pharmaceutical manufacturer that manufactured the prescription drug that is the subject of such 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 Insurance 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 year for the prescription drug that is the subject of such complaint, and (2) utilization of the prescription drug that is the subject of the complaint under the relevant health benefit plan.

(d) (1) The Insurance Commissioner shall (A) review each complaint and response submitted pursuant to subsections (b) and (c) of this section, and (B) determine whether the increase in the cost of the prescription drug caused the premium of the health benefit plan to increase by at least one dollar per member, per month.

(2) If the commissioner determines, pursuant to subdivision (1) of this subsection, that the increase in the cost of the prescription drug caused the premium of the health benefit plan to increase by at least one dollar per member, per month, the commissioner shall (A) certify such determination, and (B) issue written notice of such determination, in a form and manner prescribed by the commissioner, to the health carrier and the pharmaceutical manufacturer.

(e) If the wholesale acquisition cost of a prescription drug increases by at least twenty-five per cent during the immediately preceding calendar year, the pharmaceutical manufacturer that manufactured such drug shall submit to the Insurance 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 such drug.

(f) The quality and types of information and data that a pharmaceutical manufacturer submits to the Insurance Commissioner pursuant to 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.

(g) The Insurance 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 by this section on the state and pharmaceutical manufacturers.

(h) Except as otherwise provided in subsection (e) of this section, information and data submitted to the Insurance 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. 6. 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) "Abbreviated new drug application" has the same meaning as provided in Section 314.3 of Title 21 of the Code of Federal Regulations.

(2) "Accelerated approval" has the same meaning as provided in 21 USC 356.

(3) "Biologics license application" means an application filed pursuant to Section 601.2 of Title 21 of the Code of Federal Regulations.

(4) "Breakthrough therapy" has the same meaning as provided in 21 USC 356.

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

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

(7) "Fast track product" has the same meaning as provided in 21 USC 356.

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

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

(10) "New drug application" has the same meaning as provided in Section 314.3 of Title 21 of the Code of Federal Regulations.

(11) "New molecular entity" has the same meaning as such term is used in 21 USC 355-1.

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

(13) "Orphan drug" has the same meaning as provided in Section 316.3 of Title 21 of the Code of Federal Regulations.

(14) (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, as amended by this act, (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 include 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.

(15) "Pipeline drug" means a drug containing a new molecular entity for which a sponsor has filed a new drug application or biologics license application with, and received an action date from, the federal Food and Drug Administration.

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

(17) "Priority review" has the same meaning as such term is used in 21 USC 356.

(18) "Rebate" means a 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.

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

(20) "Sponsor" has the same meaning as provided in Section 316.3 of Title 21 of the Code of Federal Regulations.

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

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

(3) Coordinating the state's health information technology initiatives;

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

(5) 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.

(d) Beginning on January 1, 2019, each sponsor shall submit to the office, in a form and manner specified by the office, written notice informing the office that the sponsor has filed with the federal Food and Drug Administration:

(1) A new drug application or biologics license application for a pipeline drug not later than sixty days after such sponsor's receipt of an action date from the federal Food and Drug Administration regarding such application;

(2) An abbreviated new drug application for a generic drug not later than sixty days after such sponsor filed such application; or

(3) A biologics license application for a biosimilar drug not later than sixty days after such sponsor's receipt of an action date from the federal Food and Drug Administration regarding such application.

(e) (1) Beginning on January 1, 2019, the office may conduct a study, not more frequently than once annually, of each pharmaceutical manufacturer of a pipeline drug that, in the opinion of the executive director of the office, may have a significant impact on state expenditures for drugs. The office may contract with a third party,

including, but not limited to, an accounting firm, to conduct such study.

(2) Each pharmaceutical manufacturer that is the subject of a study conducted pursuant to subdivision (1) of this subsection shall submit to the office, or any contractor engaged by the office to perform such study, the following information for the pipeline drug that is the subject of such study:

(A) The primary disease, condition or therapeutic area studied in connection with such drug and whether such drug is therapeutically indicated for such disease, condition or therapeutic area;

(B) Each route of administration studied for such drug;

(C) Clinical trial comparators, if applicable, for such drug;

(D) The estimated year of market entry for such drug;

(E) Whether the federal Food and Drug Administration has designated such drug as an orphan drug, a fast track product or a breakthrough therapy; and

(F) Whether the federal Food and Drug Administration has designated such drug for accelerated approval and, if such drug contains a new molecular entity, for priority review.

(f) (1) On or before March 1, 2019, and annually thereafter, the office, in consultation with the Comptroller, Commissioner of Social Services, Insurance Commissioner and Commissioner of Public Health, shall prepare a list of not more than ten prescription drugs that the executive director of the office, in the executive director's discretion, determines are (A) provided at substantial cost to the state, considering the net cost of such drugs, or (B) critical to public health. The list shall include prescription drugs from different therapeutic classes of drugs and at least one generic prescription drug. The office shall not list any prescription drug under this subdivision unless the

wholesale acquisition cost of the prescription drug, less all rebates paid to the state for such prescription drug during the immediately preceding calendar year, increased by at least twenty-five per cent during the immediately preceding calendar year.

(2) (A) The pharmaceutical manufacturer of a prescription drug included on a list prepared by the office pursuant to subdivision (1) of this subsection shall provide to the office, in a form and manner specified 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 executive director of the office, in the executive director's discretion, deems relevant for the most recent year for which final audited data are available.

(B) 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.

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

(g) Not later than May 1, 2019, and annually thereafter, the office shall post the information the office receives pursuant to subsection (b) of section 2 of this act on the office's Internet web site.

(h) Not later than June 1, 2019, and annually thereafter, the office shall publish a report that includes the following information:

(1) All information that the office received pursuant to subsections (e) and (f) of this section;

(2) Any information that the office has collected from any commissioner, officer or agency of the state concerning the cost of prescription drugs, including, but not limited to, information concerning the historical cost of prescription drugs in this state, any legal action against pharmaceutical manufacturers implicating the cost of prescription drugs, and the marketing budgets of pharmaceutical manufacturers; and

(3) Any other publicly available information that the executive director of the office, in the executive director's discretion, deems relevant to the cost of prescription drugs in this state.

(i) Except as otherwise provided in this section, information and data submitted to the office pursuant to this section 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 (1) that is likely to compromise the financial, competitive or proprietary nature of information and data, or (2) would enable a third party to identify a pharmaceutical manufacturer, health carrier, health benefit plan, an individual drug, therapeutic class of drugs, the prices charged for any particular drug or therapeutic class of drugs, or the value of any rebate provided for any particular drug or therapeutic class of drugs.

[(c)**]** (j) The **[**Office of Health Strategy**]** office 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)**]** (k) Any order or regulation of the entities listed in subdivisions (1) and (2) of subsection **[**(c)**]** (j) 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.

(l) The Commissioner of Public Health may impose a penalty of not more than fifteen thousand dollars for a violation of this section.

(m) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

Sec. 7. 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. 8. 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 certification 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, not publish or otherwise reveal any information regarding the value of any rebate received by such managed care organization.

Sec. 9. 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*	38a-479aaa
Sec. 2	*January 1, 2019*	New section
Sec. 3	*January 1, 2019*	New section
Sec. 4	*January 1, 2019*	New section
Sec. 5	*January 1, 2019*	New section
Sec. 6	*January 1, 2019*	19a-754a
Sec. 7	*January 1, 2019*	38a-477d(a)
Sec. 8	*January 1, 2019*	38a-478j

Sec. 9	*January 1, 2019*	38a-479bbb

Statement of Legislative Commissioners:
Section 2(a)(3) was rewritten for clarity; in Section 4(b), "the Insurance Commissioner to make a" was inserted for clarity; in Section 5(b)(1), "Beginning on" was changed to "Not later than" for clarity; and in Section 5(e) "an amount that is not less than the amount specified in subparagraph (C) of subdivision (1) of subsection (b) of this section" was changed to "at least twenty-five per cent during the immediately preceding calendar year" for conciseness.

INS *Joint Favorable Subst.*