House of Representatives

General Assembly

File No. 287

January Session, 2019

Substitute House Bill No. 7174

House of Representatives, April 2, 2019

The Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING PRESCRIPTION DRUGS.

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

Section 1. (NEW) (*Effective October 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) "Participating individual" means an individual resident of this state who is participating in the program;

(3) "Participating pharmacist" means a pharmacist who is participating in the program;

(4) "Participating pharmacy" means a pharmacy that is participating in the program;

(5) "Pharmacist" has the same meaning as provided in section 38a-

479aaa of the general statutes;

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

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

(8) "Program" means the Connecticut Prescription Drug Program established by the Comptroller pursuant to subsection (b) of this section; and

(9) "Program price" means the reimbursement rates and prescription drug prices established under the program.

(b) The Comptroller shall, within available appropriations, establish the Connecticut Prescription Drug Program. The purposes of the program shall be to: (1) Purchase outpatient prescription drugs, replenish supplies of outpatient prescription drugs or reimburse participating pharmacies and participating pharmacists for outpatient prescription drugs in order to secure the lowest possible prices and greatest possible rebates for outpatient prescription drugs prescribed to participating individuals; (2) make outpatient prescription drugs available at the lowest possible cost to participating individuals; (3) maintain a list of the most cost-effective and therapeutically effective outpatient prescription drugs available to participating individuals; (4) purchase and provide discounted outpatient prescription drugs to participating individuals; and (5) coordinate a comprehensive pharmacy benefit for participating individuals.

(c) (1) As part of the program, the Comptroller shall: (A) Establish eligibility criteria for individual residents of this state, as well as pharmacies and pharmacists, to participate in the program; (B) prescribe an application form for (i) individual residents of this state to become participating individuals, (ii) pharmacists to become participating pharmacists, and (iii) pharmacies to become participating pharmacies; (C) issue to participating individuals a prescription drug

identification card containing the information necessary for claims processing; (D) establish a list of preferred outpatient prescription drugs for the program; (E) negotiate with pharmaceutical manufacturers and other persons to secure discounts and rebates for outpatient prescription drugs; (F) establish program prices; (G) adjudicate pharmacy claims and reimburse participating pharmacies and participating pharmacists at program prices; (H) develop a system for allocating and distributing the operational costs of the program, as well as any rebates, to participating individuals; and (I) charge administrative fees to participating individuals, participating pharmacists and participating pharmacies to cover the operational costs of the program, and deposit such fees in the account established under section 2 of this act.

(2) As part of the program, the Comptroller may: (A) Purchase outpatient prescription drugs on behalf of participating individuals; or (B) cooperate with other states or regional consortia to purchase outpatient prescription drugs on behalf of participating individuals.

(3) The Comptroller may enter into a contract with a pharmacy benefits manager to perform the Comptroller's duties under subdivisions (1) and (2) of this subsection, provided the Comptroller shall require the pharmacy benefits manager to charge such pharmacy benefits manager's lowest available rate to perform such duties.

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

Sec. 2. (NEW) (*Effective October 1, 2019*) There is established an account to be known as the "Connecticut Prescription Drug Program account" which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Comptroller for the purposes of the Connecticut Prescription Drug Program established pursuant to section 1 of this act.

Sec. 3. (NEW) (*Effective October 1, 2019*) (a) Each pharmaceutical manufacturer doing business in this state that manufactures a brand name prescription drug and enters into an agreement with another pharmaceutical manufacturer for the purpose of delaying or preventing such other manufacturer from introducing a generic substitute for such drug into the marketplace shall, not later than thirty days after entering into such agreement, send notice to the Insurance Commissioner, in a form and manner prescribed by the commissioner, disclosing the name of such drug.

(b) (1) The commissioner shall, not later than thirty days after receiving a notice pursuant to subsection (a) of this section, send notice to each health carrier, as defined in section 38a-1080 of the general statutes, and pharmacy benefits manager, as defined in section 38a-479aaa of the general statutes, doing business in this state. Such notice shall, at a minimum:

(A) Disclose the name of the brand name prescription drug that is the subject of the notice the commissioner received pursuant to subsection (a) of this section; and

(B) Instruct such health carrier, if such health carrier includes such drug on such health carrier's drug formulary or list of covered drugs, or pharmacy benefits manager, if such pharmacy benefits manager administers a prescription drug benefit that includes such drug, to immediately reduce the cost of such drug to covered individuals by an amount that is equal to fifty per cent of the manufacturer's wholesale list price for such drug.

(2) For the purposes of this subsection, "manufacturer's wholesale list price" has the same meaning as provided in section 21a-126 of the general statutes.

(c) The provisions of this section shall apply to the maximum extent permitted by applicable law.

(d) The commissioner may adopt regulations, in accordance with

chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 4. Subdivision (3) of subsection (m) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(3) (A) **[**(i)**]** For the purposes of this subdivision:

(i) "Nonstate public employer" means (I) a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library, as defined in section 11-24a, or (II) the Teachers' Retirement Board; and

(ii) "Qualified private employer" means a self-insured private employer doing business in this state.

(B) The Comptroller shall offer nonstate public employers and qualified private employers the option to purchase prescription drugs for their employees, employees' dependents and retirees under the purchasing authority of the state pursuant to section 1 of public act 09-206, subject to the provisions of subparagraph **[**(E)**]** (F) of this subdivision.

[(ii) For purposes of this subdivision, "nonstate public employer" means (I) a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library, as defined in section 11-24a, or (II) the Teachers' Retirement Board.**]**

[(B)**]** (C) The Comptroller shall establish procedures to determine (i) the eligibility requirements for, (ii) the enrollment procedures for, (iii) the duration of, (iv) requirements regarding payment for, and (v) the procedures for withdrawal from and termination of, the purchasing of prescription drugs for nonstate public employers and qualified private employers under subparagraph **[**(A)**]** (B) of this subdivision.

[(C)**]** (D) The Comptroller may offer to nonstate public employers and qualified private employers that choose to purchase prescription

drugs pursuant to subparagraph [(A)] (B) of this subdivision the option to purchase stop loss coverage from an insurer at a rate negotiated by the Comptroller.

[(D)] (E) Two or more nonstate public employers or qualified private employers may join together for the purpose of purchasing prescription drugs for their employees, employees' dependents and retirees. Such arrangement shall not constitute a multiple employer welfare arrangement, as defined in Section 3 of the Employee Retirement Income Security Act of 1974, as amended from time to time.

[(E)] (F) (i) The Comptroller shall offer nonstate public employers and qualified private employers the option to purchase prescription drugs through the plan set forth in the State Employees' Bargaining Agent Coalition's collective bargaining agreement with the state only if the Health Care Cost Containment Committee, established in accordance with the ratified agreement between the state and said coalition pursuant to subsection (f) of section 5-278, has indicated in writing to the Comptroller that allowing such nonstate public employers and qualified private employers such option is consistent with said coalition's collective bargaining agreement.

(ii) Such writing shall not be required if the Comptroller establishes a separate prescription drugs purchasing plan or plans for nonstate public employers and qualified private employers.

(iii) Nonstate public employers and qualified private employers that purchase prescription drugs pursuant to this subdivision shall pay the full cost of their own claims and prescription drugs.

Sec. 5. Section 38a-477cc of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) [On and after January 1, 2018, no] No contract for pharmacy services entered into in the state between a health carrier, as defined in section 38a-591a, or pharmacy benefits manager, as defined in section

38a-479aaa, and a pharmacy or pharmacist shall:

(1) On and after January 1, 2018, contain a provision prohibiting or penalizing, including through increased utilization review, reduced payments or other financial disincentives, a pharmacist's disclosure to an individual purchasing prescription medication of information regarding: [(1) the]

(A) The cost of the prescription medication to the individual; [,] or [(2) the]

(B) The availability of any therapeutically equivalent alternative medications or alternative methods of purchasing the prescription medication, including, but not limited to, paying a cash price, that are less expensive than the cost of the prescription medication to the individual; [.] and

(2) On and after January 1, 2020, contain a provision permitting the health carrier or pharmacy benefits manager to recoup, directly or indirectly, from a pharmacy or pharmacist any portion of a claim that such health carrier or pharmacy benefits manager has paid to the pharmacy or pharmacist, unless such recoupment is permitted under section 38a-479iii or required by applicable law.

(b) (1) On and after January 1, 2018, no health carrier or pharmacy benefits manager shall require an individual to make a payment at the point of sale for a covered prescription medication in an amount greater than the lesser of: [(1) the]

(A) The applicable copayment for such prescription medication; [, (2) the]

(B) The allowable claim amount for the prescription medication; [,] or [(3) the]

(C) The amount an individual would pay for the prescription medication if the individual purchased the prescription medication without using a health benefit plan, as defined in section 38a-591a, or

any other source of prescription medication benefits or discounts.

(2) For the purposes of this subsection, "allowable claim amount" means the amount the health carrier or pharmacy benefits manager has agreed to pay the pharmacy for the prescription medication.

(c) Any provision of a contract that violates the provisions of this section shall be void and unenforceable. Any general business practice that violates the provisions of this section shall constitute an unfair trade practice pursuant to chapter 735a. The invalidity or unenforceability of any contract provision under this subsection shall not affect any other provision of the contract.

(d) The Insurance Commissioner may: **[**, (1) pursuant to the provisions of chapter 697, enforce**]**

(1) Enforce the provisions of this section **[**,**]** pursuant to chapter 697; and

(2) **[**upon**]** Upon request, audit a contract for pharmacy services for compliance with the provisions of this section.

Sec. 6. (*Effective from passage*) (a) There is established a task force to study drug reimportation. Such study shall include, but need not be limited to, an examination of the feasibility of implementing a drug reimportation program for the purpose of lowering the cost of prescription drugs and health insurance in this state.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives;

(2) Two appointed by the president pro tempore of the Senate;

(3) One appointed by the majority leader of the House of Representatives;

(4) One appointed by the majority leader of the Senate;

(5) One appointed by the minority leader of the House of Representatives;

(6) One appointed by the minority leader of the Senate;

(7) The Attorney General, or the Attorney General's designee;

(8) The Comptroller, or the Comptroller's designee;

(9) The Insurance Commissioner, or the commissioner's designee;

(10) The Commissioner of Public Health, or the commissioner's designee;

(11) The Commissioner of Social Services, or the commissioner's designee;

(12) The executive director of the Office of Health Strategy, or the executive director's designee;

(13) The Healthcare Advocate, or the Healthcare Advocate's designee; and

(14) Two persons appointed by the Governor.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the

General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the task force.

(g) Not later than January 1, 2020, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2020, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2019*	New section
Sec. 2	*October 1, 2019*	New section
Sec. 3	*October 1, 2019*	New section
Sec. 4	*October 1, 2019*	5-259(m)(3)
Sec. 5	*October 1, 2019*	38a-477cc
Sec. 6	*from passage*	New section

Statement of Legislative Commissioners:
In Section 3(b)(2), "subdivision" was changed to "subsection" for accuracy.

INS *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 20 $	FY 21 $
Comptroller; State Comptroller - Fringe Benefits[1]	GF – Potential Cost	Up to $50,000	None
State Comptroller - Fringe Benefits (State Employee and Retiree Health Plan)	GF&TF – Potential Savings	See Below	See Below
Insurance Dept.	IF - Cost	Up to $2,250	Up to $3,000

Note: GF=General Fund; GF&TF=General Fund & Transportation Fund; IF=Insurance Fund

Municipal Impact:

Municipalities	Effect	FY 20 $	FY 21 $
All Municipalities	Potential Savings	See Below	See Below

Explanation

The bill's requirements result in the following fiscal impact to the state and municipalities:

Sections 1 and 2 may result in a cost of up to $50,000 to the Office of the State Comptroller (OSC) in FY 20 related to start-up costs for the Connecticut Prescription Drug Program (CPDP). The potential cost is related to (1) outside consultant services, including those of a pharmacy benefit manager (PBM) to design and provide the

[1] The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.19% of payroll in FY 20 and FY 21.

framework for the plan, and (2) $45,000 to support partial year salary and fringe benefit costs for an additional Retirement and Benefits Officer ($31,500 in salary and $13,000 in fringe benefits)[2]. In addition the cost of providing member support and outreach for participating individuals prior to administrative fees being realized by OSC.

The bill requires OSC to charge administrative fees to participating individuals, pharmacists and pharmacies to cover the operational costs of the program and deposit those fees in a separate non-lapsing account within the General Fund. Therefore ongoing administrative costs of the program including but not limited staff costs are anticipated to be covered by revenue generate by the fee.

The bill permits OSC to contract with a PBM to fulfill the requirements of the bill with respect to the CPDP but does not expressly require it. Provided the level of expertise required and based on the current provision of pharmacy benefits operated by OSC it is likely OSC will use a PBM for the CPDP. [3]

Section 3 may result in a savings to the state and municipalities to the extent drug manufactures, doing business in the state, engage in agreements to delay generic drug manufacturing and therefore are required to reduce the cost of the named drug by 50% in accordance with the bill. The savings will depend on (1) the specific drug for which the agreement applies; (2) the manufacturer's wholesale list price, or equivalent[4], of the drug; and (3) the extent to which the provisions of this section are permissible under federal law.[5] For reference the state employee and retiree health plan spent

[2] Based on entry level annual salary for a retirement benefits officer of approximately $63,200.

[3] The Oregon Health Authority and Washington State Health Authority operate prescription drug discount programs consistent with the program established in the bill. Both states utilize a PBM to administer the program including paying claims and negotiating with manufacturers.

[4] Pursuant to CGS 21a-126, a "manufacturer's wholesale list price" is a manufacturer's published wholesale price or, if there is no such published or list price, the wholesaler's invoice price, excluding discounts, to the retailer.

[5] Source: Testimony submitted to Insurance Committee: Pharmaceutical Research and Manufacturers of America (February 28, 2019).

approximately $359 million (net of pharmacy rebates) in FY 18 on prescription drugs for state employees, retirees and their dependents. [6] Pursuant to the SEBAC 2011 Agreement, the state plan requires generic substitution. For illustrative purposes, based on the most recent plan data available, the average cost per generic prescription for the active employee group was 95% less (approximately $700) than the average cost of a preferred brand prescription. It is uncertain what impact the bill will have on the availability or price of pharmaceuticals in the market and therefore the scope of the impact to the state and municipal health plans.

This section results in a cost to the Insurance Department (CID) of up to $2,250 in FY 20 and $3,000 in FY 21 for mailing expenses, and depends on the volume of agreements to delay generic drug manufacturing by manufacturers. The bill requires CID to send notice to all Connecticut health carriers and pharmacy benefit managers, instructing them to reduce the cost of the drug involved to individuals covered under their plans. FY 20 reflects a partial year, given the October 1, 2019, effective date.

Section 4 is not anticipated to result in a fiscal impact to the state or municipalities by providing access for self-insured private employers to OSC pharmaceutical purchasing authority. Municipalities are permitted under current law to access state plan prescription pricing through OSC; there are no additional bulk purchasing savings associated with the bill that cannot already be achieved. In addition, consistent with current law regarding participating municipalities, private employers are responsible for the full cost of their claims and prescription costs.

Section 5 does not result in a fiscal impact to the state or municipalities as it pertains to certain financial transactions between health carriers or pharmacy benefit managers (PBMs) and pharmacies or pharmacist.

[6] Source: Office of the State Comptroller

Section 6 does not result in a fiscal impact to the state agencies specified in the bill to be part of the task force established by the bill as the agencies have the expertise to do so.

The Out Years

The annualized ongoing fiscal impact identified above will continue into the future subject to (1) the potential impact to pharmaceutical prices resulting from the bill's provisions regarding agreements to delay generic drug manufacturing and (2) mailing expenses incurred by DOI.

OLR Bill Analysis
sHB 7174

AN ACT CONCERNING PRESCRIPTION DRUGS.

SUMMARY

This bill requires the comptroller, within available appropriations, to establish the Connecticut Prescription Drug Program (CPDP) to, among other things, make outpatient prescription drugs available to program participants at the lowest possible cost.

It also requires pharmaceutical manufacturers engaging in agreements to delay generic drug manufacturing (e.g., "pay-for-delay" agreements) to report such agreements to the Insurance Commissioner, who must notify other health carriers about the drug covered by the agreement. Under the bill, health carriers covering drugs subject to one of these notices must reduce the cost of the drug to covered individuals by 50%.

The bill also:

1. allows certain self-insured private employers to access the prescription drug benefit portion of the state employee and retiree health plan;
2. prohibits contracts between pharmacy benefit managers (PBMs) and pharmacies from allowing the PBM to recoup any portion of a settled claim, except under an audit; and
3. establishes a drug reimportation task force.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2019, except for the task force, which is effective upon passage.

§§ 1 & 2 — CONNECTICUT PRESCRIPTION DRUG PROGRAM (CPDP)

The bill requires the comptroller to establish the CPDP, within available appropriations, to:

1. purchase outpatient prescription drugs, replenish supplies of such drugs, or reimburse participating pharmacies and pharmacists for outpatient prescription drugs in order to secure the lowest possible prices and greatest possible rebates for program participants;

2. make outpatient prescription drugs available to participants at the lowest possible cost;

3. maintain a list of the most cost-effective and therapeutically effective outpatient prescription drugs available to participants;

4. purchase and provide discounted outpatient prescription drugs to participants; and

5. coordinate a comprehensive pharmacy benefit for participants.

To do this, the bill authorizes the comptroller to, either by himself or in cooperation with other states or regional consortia, purchase outpatient prescription drugs on participating individuals' behalf.

Comptroller Requirements

As part of the program, the comptroller must:

1. establish eligibility criteria for Connecticut residents and participating pharmacies and pharmacists;

2. prescribe an application for individuals, pharmacists, and pharmacies to participate in the program;

3. issue to participating individuals a prescription drug identification card that contains claims processing information;

4. establish a list of preferred outpatient prescription drugs for the

program;

5. negotiate with pharmaceutical manufacturers and others to secure prescription drug discounts and rebates;

6. establish program prices;

7. adjudicate pharmacy claims and reimburse participating pharmacies and pharmacists at program prices;

8. develop a system to allocate and distribute program operations costs, as well as any rebates, to individual participants.

CPDP Account

Under the bill, the comptroller must also charge administrative fees to individual program participants, as well as participating pharmacists and pharmacies, to cover the program's operational costs. Money from the fees must be deposited in the Connecticut prescription drug program account, which the bill creates as a separate nonlapsing account in the General Fund. Money in the account must be used to facilitate the CPDP.

Program Implementation and Administration

The comptroller may contract with a PBM to run the program, as long as he requires the PBM to charge its lowest available rate for such services. The bill also authorizes him to adopt implementing regulations.

§ 3 — AGREEMENTS TO DELAY GENERIC DRUG MANUFACTURING

Under the bill, each brand name drug manufacturer that conducts business in Connecticut and enters into an agreement with another manufacturer to delay the introduction of a generic replacement drug must, within 30 days, notify the insurance commissioner of the brand name drug's name in a form and manner he prescribes.

Within 30 days of receiving such a notice, the commissioner must:

1. notify and disclose to all health carriers and PBMs doing business in Connecticut that the brand name prescription drug is subject to such an agreement, and

2. instruct health carriers covering the brand name drug, and PBMs administering plans that include the drug, to immediately reduce the drug's cost by 50% of the manufacturer's wholesale list price.

A "manufacturer's wholesale list price" is a manufacturer's published wholesale price or, if there is no such published or list price, the wholesaler's invoice price, excluding discounts, to the retailer.

These provisions apply to the maximum extent permitted by law. The bill allows the commissioner to adopt implementing regulations.

§ 4 — SELF-INSURED PRIVATE EMPLOYER ACCESS TO THE PRESCRIPTION DRUG BENEFIT PORTION OF THE STATE EMPLOYEE AND RETIREE HEALTH PLAN

By law, certain nonstate public employers (e.g., municipalities, quasi-public agencies, and boards of education) can purchase prescription drugs through the state employee and retiree health plan administered by the comptroller. The bill allows a self-insured private employer, either individually or together with other self-insured private employers, to also purchase prescription drug coverage through the plan. It also incorporates self-insured private employers into existing law's plan administration provisions, thus:

1. requiring the commissioner to establish eligibility, enrollment, payment, and withdrawal procedures for self-insured private employers;

2. allowing the comptroller to offer self-insured private employers the option to purchase stop loss coverage at a negotiated rate; and

3. requiring self-insured private employers to pay the full cost of their own claims and prescription drugs.

As under existing law for nonstate public employers, the comptroller must either establish or incorporate self-insured private employers into a separate plan or receive approval from the Health Care Cost Containment Committee.

§ 5 — PBM PAYMENTS

Beginning January 1, 2020, the bill prohibits a contract between a health carrier or PBM and a pharmacy or pharmacist from allowing the health carrier or PBM to recoup, directly or indirectly, any portion of a claim that was paid to the pharmacy or pharmacist. The bill excludes any payments made due to a pharmacy audit or authorized by another applicable law.

§ 6 — DRUG REIMPORTATION TASK FORCE

The bill establishes a task force to study drug reimportation and requires it to report to the Insurance and Real Estate Committee with its findings by January 1, 2020, at which point it terminates. The study must include an examination of the feasibility of implementing a importation program to lower prescription drug and health insurance costs.

Under the bill, the task force consists of:

1. two members appointed by the House Speaker;
2. two appointed by the Senate President Pro Tempore;
3. one each appointed by the House and Senate majority leaders;
4. one each appointed by the House and Senate minority leaders;
5. the attorney general, comptroller, and the public health, social services, and insurance commissioners, or their designees;
6. the Office of Health Strategy executive director and the healthcare advocate, or their designees; and
7. two appointed by the governor.

The bill does not specify qualifications for appointees. It allows the legislative appointees to be legislators. Appointments must be made within 30 days of the bill's passage, and vacancies are filled by the appointing authority.

The House Speaker and the Senate President Pro Tempore must select the chairpersons from among the task force's members. The chairpersons must schedule the first meeting within 60 days of the bill's passage.

Under the bill, the Insurance and Real Estate Committee's staff serves as the task force's administrative staff.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 12 Nay 8 (03/14/2019)