House of Representatives

General Assembly

File No. 383

January Session, 2021

Substitute House Bill No. 6447

House of Representatives, April 12, 2021

The Committee on Insurance and Real Estate reported through REP. WOOD, K. of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CREATING THE COVERED CONNECTICUT PROGRAM TO EXPAND ACCESS TO AFFORDABLE HEALTH CARE.

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

Section 1. Subsections (a) and (b) of section 19a-754a of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) 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) The Office of Health Strategy 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) Promoting effective health planning and the provision of quality

health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

(3) Directing and overseeing the State Innovation Model Initiative and related successor initiatives;

(4) (A) Coordinating the state's health information technology initiatives, (B) seeking funding for and overseeing the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 19a-775a, (C) establishing and maintaining a consumer health information Internet web site under section 19a-755b, and (D) designating an unclassified individual from the office to perform the duties of a health information technology officer as set forth in sections 17b-59f and 17b-59g;

(5) Directing and overseeing the Health Systems Planning Unit established under section 19a-612 and all of its duties and responsibilities as set forth in chapter 368z; **[**and**]**

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

(7) Administering the Covered Connecticut account established under section 2 of this act;

(8) Annually determining the amount described in, and reporting such amount to the Insurance Commissioner pursuant to, subsection (b) of section 4 of this act;

(9) Annually (A) developing a plan, pursuant to subsection (b) of section 3 of this act, in consultation with the Connecticut Health Insurance Exchange, Commissioner of Social Services and Insurance Commissioner, and (B) submitting a report, pursuant to subsection (c)

of section 3 of this act and in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance; and

(10) Not later than February 1, 2023, and annually thereafter, providing to the Commissioner of Revenue Services a list of the drugs that the Secretary of Health and Human Services determined, pursuant to 21 USC 356e, as amended from time to time, were in shortage in the United States during the preceding calendar year.

Sec. 2. (NEW) (*Effective July 1, 2021*) There is established an account to be known as the "Covered Connecticut account" which shall be a separate, nonlapsing account within the General Fund. The account shall be administered by the Office of Health Strategy, established under section 19a-754a of the general statutes, as amended by this act, and contain any moneys required by law to be deposited in the account. Subject to the approval required under subsection (d) of section 3 of this act, moneys in the account shall be expended by the Connecticut Health Insurance Exchange, established pursuant to section 38a-1081 of the general statutes, and the Department of Social Services in accordance with the plan developed by the Office of Health Strategy pursuant to subsection (b) of section 3 of this act.

Sec. 3. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this section:

(1) "Affordable Care Act" has the same meaning as provided in section 38a-1080 of the general statutes;

(2) "Covered Connecticut account" means the Covered Connecticut account established under section 2 of this act;

(3) "Exchange" has the same meaning as provided in section 38a-1080 of the general statutes; and

(4) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act.

(b) The Office of Health Strategy shall, in consultation with the exchange, Commissioner of Social Services and Insurance Commissioner, annually develop a plan to, within the funds available in the Covered Connecticut account and without recourse to any other state funds, reduce this state's uninsured rate by, among other things, reducing the burden that health care costs impose on insureds. Such plan may, among other things, call for:

(1) The exchange to:

(A) Establish:

(i) A state subsidy program to provide premium subsidies, at defined amounts and to individuals within defined income brackets, for individuals with incomes not greater than six hundred per cent of the federal poverty level; or

(ii) A reinsurance program; or

(B) Seek, in consultation with the Office of Health Strategy, and, if issued, implement, a state innovation waiver pursuant to Section 1332 of the Affordable Care Act; or

(2) The Commissioner of Social Services to expand medical assistance under chapter 319v of the general statutes to provide coverage to additional individuals.

(c) Not later than January 1, 2022, and annually thereafter, the Office of Health Strategy shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such report shall contain the plan developed pursuant to subsection (b) of this section.

(d) Not later than February 1, 2022, and annually thereafter, the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall advise the Office of Health Strategy, exchange, Commissioner of Social Services and Insurance

Commissioner of its approval or rejection of the plan contained in the report submitted by the Office of Health Strategy pursuant to subsection (c) of this section. If the committee does not act on or before said date, said plan shall be deemed rejected.

Sec. 4. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this section:

(1) "Covered Connecticut account" means the Covered Connecticut account established under section 2 of this act;

(2) "Exempt insurer" means an insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of subdivision (11) of section 38a-720 of the general statutes and section 38a-720a of the general statutes; and

(3) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act.

(b) (1) Not later than July 1, 2022, and annually thereafter, the Office of Health Strategy shall:

(A) Determine the difference between fifty million dollars and the amount of moneys deposited that year in the Covered Connecticut account pursuant to subsection (k) of section 7 of this act; and

(B) Report the amount determined pursuant to subparagraph (A) of this subdivision to the Insurance Commissioner.

(2) The Office of Health Strategy shall, not later than July 1, 2021, report to the Insurance Commissioner that the amount described in subparagraph (A) of subdivision (1) of this subsection is thirty million dollars for the year 2022.

(c) (1) Each insurer and health care center doing health insurance business in this state, and each exempt insurer, shall annually pay to the Insurance Commissioner, for deposit in the Covered Connecticut

account, a fee assessed by the commissioner pursuant to this section.

(2) Not later than July 1, 2021, and annually thereafter, each insurer, health care center and exempt insurer described in subdivision (1) of this subsection shall report to the commissioner, on a form designated by the commissioner, the number of insured or enrolled lives in this state as of the May first immediately preceding for which such insurer, health care center or exempt insurer was providing health insurance coverage, or administering a self-insured health benefit plan providing coverage, of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes. Such number shall not include insured or enrolled lives covered under fully-insured group health insurance policies sold in the small group market, Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans.

(3) Not later than August 1, 2021, and annually thereafter, the commissioner shall determine the fee to be assessed for that year against each insurer, health care center and exempt insurer described in subdivision (1) of this subsection. Such fee shall be determined by multiplying the number of insured or enrolled lives reported to the commissioner pursuant to subdivision (2) of this subsection by a factor, determined annually by the commissioner, to fully fund the amount reported by the Office of Health Strategy to the commissioner pursuant to subsection (b) of this section. The commissioner shall determine the factor by dividing the amount reported by the Office of Health Strategy to the commissioner pursuant to subsection (b) of this section by the total number of insured or enrolled lives reported to the commissioner pursuant to subdivision (2) of this subsection.

(4) (A) Not later than August 1, 2021, and annually thereafter, the commissioner shall submit a statement to each insurer, health care center and exempt insurer described in subdivision (1) of this subsection that includes the proposed fee imposed under this section for such insurer, health care center or exempt insurer determined in accordance with this subsection. Each such insurer, health care center and exempt

insurer shall pay such fee to the commissioner not later than November first of that year.

(B) Any insurer, health care center or exempt insurer described in subdivision (1) of this subsection that is aggrieved by an assessment levied under this subsection may appeal therefrom in the same manner as provided for appeals under section 38a-52 of the general statutes.

(5) Any insurer, health care center or exempt insurer that fails to file the report required under subdivision (2) of this subsection, or pay the fee assessed under subdivision (1) of this subsection, shall pay a late filing or payment fee, as applicable, of one hundred dollars per day for each day from the date such report or payment was due. The commissioner shall deposit all late fees paid pursuant to this subdivision in the Covered Connecticut account. The commissioner may require an insurer, health care center or exempt insurer subject to this subsection to produce any records in its possession, and may require any other person to produce any records in such other person's possession, that were used to prepare such report for examination by the commissioner or the commissioner's designee. If the commissioner determines there exists anything other than a good faith discrepancy between the actual number of insured or enrolled lives that should have been reported to the commissioner pursuant to subdivision (2) of this subsection and the number actually reported, such insurer, health care center or exempt insurer shall be liable to this state for a civil penalty of not more than fifteen thousand dollars for each report filed for which the commissioner determines there is such a discrepancy.

(6) (A) The commissioner shall apply any overpayment of the fee imposed under this section by an insurer, health care center or exempt insurer for a given year as a credit against the fee due from such insurer, health care center or exempt insurer under this section for the succeeding year if:

(i) The amount of the overpayment exceeds five thousand dollars; and

(ii) On or before April first of the year following the overpayment, the insurer, health care center or exempt insurer:

(I) Notifies the commissioner of the amount of the overpayment; and

(II) Provides the commissioner with evidence sufficient to prove the amount of the overpayment.

(B) Not later than ninety days after the commissioner receives the notice and supporting evidence under subparagraph (A)(ii) of this subdivision, the commissioner shall:

(i) Determine whether the insurer, health care center or exempt insurer made an overpayment; and

(ii) Notify the insurer, health care center or exempt insurer of the commissioner's determination under subparagraph (B)(i) of this subdivision.

(C) Failure of an insurer, health care center or exempt insurer to notify the commissioner of the amount of an overpayment within the time prescribed in subparagraph (A)(ii) of this subdivision constitutes a waiver of any demand of the insurer, health care center or exempt insurer against this state on account of such overpayment.

(D) Nothing in this subdivision shall be construed to prohibit or limit the right of an insurer, health care center or exempt insurer to appeal pursuant to subparagraph (B) of subdivision (4) of this subsection.

(d) If another state, territory or district of the United States, or a foreign country, imposes on a Connecticut domiciled insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other domestic entity a retaliatory charge for the fee imposed under this section, such domestic entity may, not later than sixty days after receipt of notice of the imposition of the retaliatory charge for such fee, appeal to the Insurance Commissioner for a verification that the fee imposed under this section is subject to retaliation by another state, territory or district of the United States, or a

foreign country. If the commissioner verifies, upon appeal to and certification by the commissioner, that the fee imposed under this section is the subject of a retaliatory tax, fee, assessment or other obligation by another state, territory or district of the United States, or a foreign country, such fee shall not be assessed against nondomestic insurers and nondomestic exempt insurers pursuant to this section. Any such domestic insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity aggrieved by the commissioner's decision issued under this subsection may appeal therefrom in the same manner as provided under section 38a-52 of the general statutes.

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

Sec. 5. Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

The exchange shall:

(1) Administer the exchange for both qualified individuals and qualified employers;

(2) Commission surveys of individuals, small employers and health care providers on issues related to health care and health care coverage;

(3) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the Affordable Care Act, and section 38a-1086, of health benefit plans as qualified health plans;

(4) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(5) Provide for enrollment periods, as provided under Section 1311(c)(6) of the Affordable Care Act;

(6) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans including, but not limited to, the enrollee satisfaction survey information under Section 1311(c)(4) of the Affordable Care Act and any other information or tools to assist enrollees and prospective enrollees evaluate qualified health plans offered through the exchange;

(7) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs of the exchange, including information on moneys lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

(8) On or before the open enrollment period for plan year 2017, assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the Affordable Care Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

(9) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Service Act, 42 USC 300gg-15, as amended from time to time;

(10) Inform individuals, in accordance with Section 1413 of the Affordable Care Act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, as amended from time to time, or any applicable state or local public program, and enroll an individual in such program if the exchange determines, through screening of the application by the exchange, that such individual is eligible for any such program;

(11) Collaborate with the Department of Social Services, to the extent possible, to allow an enrollee who loses premium tax credit eligibility

under Section 36B of the Internal Revenue Code and is eligible for HUSKY A or any other state or local public program, to remain enrolled in a qualified health plan;

(12) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the Affordable Care Act;

(13) Establish a program for small employers through which qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

(14) Offer enrollees and small employers the option of having the exchange collect and administer premiums, including through allocation of premiums among the various insurers and qualified health plans chosen by individual employers;

(15) Grant a certification, subject to Section 1411 of the Affordable Care Act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

(A) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(16) Provide to the Secretary of the Treasury of the United States the following:

(A) A list of the individuals granted a certification under subdivision (15) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code because:

(i) The employer did not provide minimum essential health benefits coverage; or

(ii) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under Section 1411(b)(4) of the Affordable Care Act that such individual has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(17) Provide to each employer the name of each employee, as described in subparagraph (B) of subdivision (16) of this section, of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform duties required of, or delegated to, the exchange by the Secretary or the Secretary of the Treasury of the United States related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

(19) Select entities qualified to serve as Navigators in accordance with Section 1311(i) of the Affordable Care Act and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing reductions under Section 1402 of the Affordable Care Act;

(C) Facilitate enrollment in qualified health plans;

(D) Provide referrals to the Office of the Healthcare Advocate or health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(20) Review the rate of premium growth within and outside the exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(21) Credit the amount, in accordance with Section 10108 of the Affordable Care Act, of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer;

(22) Consult with stakeholders relevant to carrying out the activities required under sections 38a-1080 to 38a-1090, inclusive, including, but not limited to:

(A) Individuals who are knowledgeable about the health care system, have background or experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) Representatives of small employers and self-employed individuals;

(D) The Department of Social Services; and

(E) Advocates for enrolling hard-to-reach populations;

(23) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the Insurance Commissioner and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Affordable Care Act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) Not use any funds in carrying out its activities under sections 38a-1080 to 38a-1089, inclusive, that are intended for the administrative and operational expenses of the exchange, for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications;

(24) (A) Seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange, (B) encourage health carriers to offer tiered health care provider network plans that have different cost-sharing rates for

different health care provider tiers and reward enrollees for choosing low-cost, high-quality health care providers by offering lower copayments, deductibles or other out-of-pocket expenses, and (C) offer any such tiered health care provider network plans through the exchange; **[**and**]**

(25) Report at least annually to the General Assembly on the effect of adverse selection on the operations of the exchange and make legislative recommendations, if necessary, to reduce the negative impact from any such adverse selection on the sustainability of the exchange, including recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Affordable Care Act, self-insured plans, plans sold through the exchange and plans sold outside the exchange; **[**.**]** and

(26) Annually consult with the Office of Health Strategy, established under section 19a-754a, as amended by this act, Commissioner of Social Services and Insurance Commissioner to develop the annual plan required under subsection (b) of section 3 of this act and, subject to the terms of such plan, the approval required under subsection (d) of section 3 of this act and within the funds available in the Covered Connecticut account established under section 2 of this act:

(A) Seek, in consultation with the Office of Health Strategy, the state innovation waiver described in subparagraph (B) of subdivision (1) of subsection (b) of section 3 of this act, provided such plan calls for the exchange to seek such state innovation waiver; and

(B) Use the moneys deposited in the Covered Connecticut account established under section 2 of this act to carry out such plan.

Sec. 6. (NEW) (*Effective July 1, 2021*) For the purposes of this section and sections 7 and 8 of this act:

(1) "Commissioner" means the Commissioner of Revenue Services;

(2) "Consumer price index" means the consumer price index, annual average, for all urban consumers: United States city average, all items, published by the United States Department of Labor, Bureau of Labor Statistics, or its successor, or, if the index is discontinued, an equivalent index published by a federal authority, or, if no such index is published, a comparable index published by the United States Department of Labor, Bureau of Labor Statistics;

(3) "Covered Connecticut account" means the Covered Connecticut account established under section 2 of this act;

(4) "Identified prescription drug" means a prescription drug that is sold at a price that exceeds the amount described in subsection (a) of section 7 of this act;

(5) "Legend drug" has the same meaning as provided in section 20-571 of the general statutes;

(6) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act;

(7) "Person" has the same meaning as provided in section 12-1 of the general statutes;

(8) "Pharmaceutical manufacturer" means a person that manufactures a prescription drug and sells, directly or through another person, the prescription drug for distribution in this state;

(9) "Prescription drug" means a legend drug approved by the federal Food and Drug Administration, or any successor agency, and prescribed by a health care provider to an individual in this state;

(10) "Reference price" means the wholesale acquisition cost of a drug (A) on January 1, 2021, or (B) if the drug is first commercially marketed in the United States after January 1, 2021, on the date such drug is first

commercially marketed in the United States; and

(11) "Wholesale acquisition cost" has the same meaning as provided in 42 USC 1395w-3a, as amended from time to time.

Sec. 7. (NEW) (*Effective July 1, 2021*) (a) (1) Notwithstanding any provision of the general statutes and except as provided in subdivision (2) of this subsection, no pharmaceutical manufacturer shall, on or after January 1, 2022, sell a prescription drug in this state at a price that exceeds the sum of:

(A) The reference price for the prescription drug, adjusted for any increase or decrease in the consumer price index; and

(B) Two per cent of the reference price for the prescription drug for each twelve-month period that has elapsed since the date on which the reference price for such prescription drug was determined, compounded annually on the anniversary of such date.

(2) A pharmaceutical manufacturer may sell a prescription drug in this state at a price that exceeds the amount determined for the prescription drug under subdivision (1) of this subsection if the Secretary of Health and Human Services determines, pursuant to 21 USC 356e, as amended from time to time, that such prescription drug is in shortage in the United States.

(b) (1) Except as provided in subdivision (2) of this subsection, any pharmaceutical manufacturer that violates the provisions of subsection (a) of this section shall be liable to this state for a civil penalty. Such civil penalty shall be determined and collected on a calendar year basis, and the amount of such civil penalty for a calendar year shall be equal to eighty per cent of the difference between:

(A) The revenue that the pharmaceutical manufacturer earned from all sales of the identified prescription drug in this state during the calendar year; and

(B) The revenue that the pharmaceutical manufacturer would have

earned from all sales of the identified prescription drug in this state during the calendar year if the pharmaceutical manufacturer had sold such identified prescription drug at a price that did not exceed the amount described in subsection (a) of this section.

(2) No pharmaceutical manufacturer of an identified prescription drug shall be liable to this state for the civil penalty imposed under subdivision (1) of this subsection unless the pharmaceutical manufacturer made at least two hundred fifty thousand dollars in total annual sales in this state for the calendar year for which such civil penalty would otherwise be imposed.

(c) (1) (A) Not later than March 1, 2023, and annually thereafter, each pharmaceutical manufacturer that violated subsection (a) of this section during the preceding calendar year shall:

(i) Pay to the commissioner the civil penalty imposed under subsection (b) of this section for such calendar year; and

(ii) File with the commissioner a statement for such calendar year in a form and manner, and containing all information, prescribed by the commissioner.

(B) A pharmaceutical manufacturer that is required to file a statement and pay a civil penalty pursuant to subparagraph (A) of this subdivision shall electronically file such statement and make such payment by electronic funds transfer in the manner provided by chapter 228g of the general statutes, irrespective of whether the pharmaceutical manufacturer would have otherwise been required to electronically file such statement or make such payment by electronic funds transfer under chapter 228g of the general statutes.

(2) If no statement is filed pursuant to subdivision (1) of this subsection, the commissioner may make such statement at any time thereafter, according to the best obtainable information and the prescribed form.

(d) The commissioner may examine such records of a pharmaceutical

manufacturer that is subject to the civil penalty imposed under subsection (b) of this section as the commissioner deems necessary. If the commissioner determines from such examination that the pharmaceutical manufacturer failed to pay the full amount of such civil penalty, the commissioner shall bill such pharmaceutical manufacturer for the full amount of such civil penalty.

(e) (1) The commissioner may require all pharmaceutical manufacturers subject to a civil penalty imposed under this section to keep such records as the commissioner may prescribe, and may require the production of books, papers, documents and other data, to provide or secure information pertinent to the determination of the civil penalty and the enforcement and collection thereof.

(2) The commissioner, or any person authorized by the commissioner, may examine the books, papers, records and equipment of any person liable under the provisions of this section and may investigate the character of the business of such person to verify the accuracy of any statement made or, if no statement is made by the person, to ascertain and determine the amount required to be paid.

(f) Any pharmaceutical manufacturer that is subject to a civil penalty imposed under this section and aggrieved by the action of the commissioner under subdivision (2) of subsection (c) of this section or subsection (d) of this section may apply to the commissioner, in writing and not later than sixty days after the notice of such action is delivered or mailed to such pharmaceutical manufacturer, for a hearing, setting forth the reasons why such hearing should be granted and the amount by which the civil penalty should be reduced. The commissioner shall promptly consider each such application and may grant or deny the hearing requested. If the hearing request is denied, the commissioner shall immediately notify the pharmaceutical manufacturer. If the hearing request is granted, the commissioner shall notify the pharmaceutical manufacturer of the date, time and place for such hearing. After such hearing, the commissioner may make such order as appears just and lawful to the commissioner and shall furnish a copy of

such order to the pharmaceutical manufacturer. The commissioner may, by notice in writing, order a hearing on the commissioner's own initiative and require a pharmaceutical manufacturer, or any other person who the commissioner believes to be in possession of relevant information concerning such pharmaceutical manufacturer, to appear before the commissioner or the commissioner's authorized agent with any specified books of account, papers or other documents for examination under oath.

(g) Any pharmaceutical manufacturer that is aggrieved by any order, decision, determination or disallowance of the commissioner made under subsection (f) of this section may, not later than thirty days after service of notice of such order, decision, determination or disallowance, take an appeal therefrom to the superior court for the judicial district of New Britain, which appeal shall be accompanied by a citation to the commissioner to appear before said court. Such citation shall be signed by the same authority and such appeal shall be returnable at the same time and served and returned in the same manner as is required in case of a summons in a civil action. The authority issuing the citation shall take from the appellant a bond or recognizance to this state, with surety, to prosecute the appeal to effect and to comply with the orders and decrees of the court in the premises. Such appeals shall be preferred cases, to be heard, unless cause appears to the contrary, at the first session, by the court or by a committee appointed by the court. Said court may grant such relief as may be equitable and, if the civil penalty was paid prior to the granting of such relief, may order the Treasurer to pay the amount of such relief. If the appeal was taken without probable cause, the court may tax double or triple costs, as the case demands and, upon all such appeals that are denied, costs may be taxed against such pharmaceutical manufacturer at the discretion of the court but no costs shall be taxed against this state.

(h) The commissioner, and any agent of the commissioner duly authorized to conduct any inquiry, investigation or hearing pursuant to this section, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any

hearing ordered by the commissioner, the commissioner, or the commissioner's agent authorized to conduct such hearing and having authority by law to issue such process, may subpoena witnesses and require the production of books, papers and documents pertinent to such inquiry or investigation. No witness under subpoena authorized to be issued under the provisions of this section shall be excused from testifying or from producing books, papers or documentary evidence on the ground that such testimony or the production of such books, papers or documentary evidence would tend to incriminate such witness, but such books, papers or documentary evidence so produced shall not be used in any criminal proceeding against such witness. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to such person by the commissioner, or the commissioner's authorized agent, or to produce any books, papers or other documentary evidence pursuant thereto, the commissioner, or such agent, may apply to the Superior Court of the judicial district wherein the pharmaceutical manufacturer resides or wherein the business was conducted, or to any judge of such court if the same is not in session, setting forth such disobedience to process or refusal to answer, and such court or such judge shall cite such person to appear before such court or such judge to answer such question or to produce such books, papers or other documentary evidence and, upon such person's refusal so to do, shall commit such person to a community correctional center until such person testifies, but not for a period longer than sixty days. Notwithstanding the serving of the term of such commitment by any person, the commissioner may proceed in all respects with such inquiry and examination as if the witness had not previously been called upon to testify. Officers who serve subpoenas issued by the commissioner or under the commissioner's authority and witnesses attending hearings conducted by the commissioner pursuant to this section shall receive fees and compensation at the same rates as officers and witnesses in the courts of this state, to be paid on vouchers of the commissioner on order of the Comptroller from the proper appropriation for the administration of this section.

(i) The amount of any civil penalty unpaid under the provisions this

section may be collected under the provisions of section 12-35 of the general statutes. The warrant provided under section 12-35 of the general statutes shall be signed by the commissioner or the commissioner's authorized agent. The amount of any such civil penalty shall be a lien on the real property of the pharmaceutical manufacturer from the last day of the month next preceding the due date of such civil penalty until such civil penalty is paid. The commissioner may record such lien in the records of any town in which the real property of such pharmaceutical manufacturer is situated, but no such lien shall be enforceable against a bona fide purchaser or qualified encumbrancer of such real property. When any civil penalty with respect to which a lien was recorded under the provisions of this subsection is satisfied, the commissioner shall, upon request of any interested party, issue a certificate discharging such lien, which certificate shall be recorded in the same office in which such lien was recorded. Any action for the foreclosure of such lien shall be brought by the Attorney General in the name of this state in the Superior Court for the judicial district in which the real property subject to such lien is situated, or, if such property is located in two or more judicial districts, in the Superior Court for any one such judicial district, and the court may limit the time for redemption or order the sale of such real property or make such other or further decree as it judges equitable. The provisions of section 12-39g of the general statutes shall apply to all civil penalties imposed under this section.

(j) (1) Any officer or employee of a pharmaceutical manufacturer who owes a duty to the pharmaceutical manufacturer to pay a civil penalty imposed under this section on behalf of such pharmaceutical manufacturer, file a statement with the commissioner pursuant to subsection (c) of this section on behalf of such pharmaceutical manufacturer, keep records or supply information to the commissioner on behalf of such pharmaceutical manufacturer pursuant to this section and wilfully fails, at the time required under this section, to pay such civil penalty, file such statement, keep such records or supply such information on behalf of such pharmaceutical manufacturer shall, in addition to any other penalty provided by law, be fined not more than

one thousand dollars or imprisoned not more than one year, or both. Notwithstanding the provisions of section 54-193 of the general statutes, no such officer or employee shall be prosecuted for a violation of the provisions of this subdivision committed on or after July 1, 2021, except within three years next after such violation is committed.

(2) Any officer or employee of a pharmaceutical manufacturer who owes a duty to the pharmaceutical manufacturer to deliver or disclose to the commissioner, or the commissioner's authorized agent, any list, statement, return, account statement or other document on behalf of such pharmaceutical manufacturer and wilfully delivers or discloses to the commissioner, or the commissioner's authorized agent, any such list, statement, return, account statement or other document that such officer or employee knows to be fraudulent or false in any material matter shall, in addition to any other penalty provided by law, be guilty of a class D felony.

(3) No officer or employee of a pharmaceutical manufacturer shall be charged with an offense under subdivisions (1) and (2) of this subsection in relation to the same civil penalty, but such officer or employee may be charged and prosecuted for both such offenses upon the same information.

(k) The proceeds from all civil penalties imposed under this section shall be deposited in the Covered Connecticut account. Each civil penalty imposed under this section shall be deemed to constitute a civil fine or penalty within the meaning of 42 USC 1396b(w), as amended from time. No portion of any civil penalty imposed under this section shall be waived under section 12-3a of the general statutes or any other applicable law. No tax credit shall be allowable against any civil penalty imposed under this section.

(l) Not later than July 1, 2023, and annually thereafter, the commissioner shall prepare a list containing the name of each pharmaceutical manufacturer that violated subsection (a) of this section during the preceding calendar year. The commissioner shall make each list publicly available.

(m) 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. 8. (NEW) (*Effective July 1, 2021*) (a) No pharmaceutical manufacturer of an identified prescription drug shall withdraw the identified prescription drug from sale in this state for the purpose of avoiding the civil penalty imposed under subsection (b) of section 7 of this act.

(b) Any pharmaceutical manufacturer that intends to withdraw an identified prescription drug from sale in this state shall send advance written notice to the Office of Health Strategy disclosing such pharmaceutical manufacturer's intention at least one hundred eighty days before such withdrawal.

(c) Any pharmaceutical manufacturer that violates any provision of subsection (a) or (b) of this section shall be liable to this state for a civil penalty in the amount of five hundred thousand dollars.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2021*	19a-754a(a) and (b)
Sec. 2	*July 1, 2021*	New section
Sec. 3	*July 1, 2021*	New section
Sec. 4	*July 1, 2021*	New section
Sec. 5	*July 1, 2021*	38a-1084
Sec. 6	*July 1, 2021*	New section
Sec. 7	*July 1, 2021*	New section
Sec. 8	*July 1, 2021*	New section

Statement of Legislative Commissioners:
In Section 3(a), Subdiv. (5) was deleted to eliminate an unnecessary definition.

INS *Joint Favorable Subst.*

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 22 $	FY 23 $
Insurance Dept.; Department of Revenue Services	GF - Revenue Gain	Approx. 30 million	Approx. 50 million
Department of Revenue Services	GF - Cost	None	Less than 100,000
Department of Revenue Services	GF - Potential Cost	Less than 500,000	Less than 500,000
The Exchange; Social Services, Dept.	GF - Potential Cost	See Below	See Below
The Exchange	GF - Potential Revenue Gain	None	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill requires the Office of Health Strategy (OHS), in consultation with the Connecticut Health Insurance Exchange ("exchange") and the Department of Social Services (DSS) and insurance commissioners, to create a plan for a Covered Connecticut program to reduce the state's uninsured rate. There is no anticipated cost to OHS to develop the plan.

The bill establishes the Covered Connecticut Account, a separate non-lapsing General Fund account, to contain all funding for the new program. The bill results in a revenue gain to this account of at least $30 million in FY 22 and at least $50 million in FY 23 and annually thereafter. Revenue in FY 23 and thereafter comes from the combination of 1) fines on pharmaceutical manufacturers that violate the provisions of the bill and 2) an annual assessment on health insurers, HMOs, and exempt

insurers collected by the Insurance Department (DOI) to cover the funding gap between the fine revenue and $50 million. In FY 22, the revenue is only from the health carriers' assessment, which is set at $30 million. The bill authorizes DOI to collect late fees of $100 a day and assess civil penalties of up to $15,000 for other than a "good faith discrepancy" in a carrier's reporting associated with the assessment, which could result in additional minimal revenue to the account. There is no anticipated cost to DOI to carry out the assessment, as it is similar to others the agency collects from the same entities.

The bill results in an annual cost to the exchange and DSS, up to the amount of funding available in the Covered Connecticut Account, to implement the Covered Connecticut program if the plan is approved by the Insurance and Real Estate Committee each year. The cost will vary based on the components included in the program and each component's design. The plan may call for the exchange to establish a state health insurance premium subsidy program, a reinsurance program, and apply for and implement a federal Section 1332 state innovation waiver. If the plan calls for the exchange to apply for a state innovation waiver, there will be a cost of at least $100,000 for an actuarial report to support the state's application. The plan may also call for DSS to expand eligibility for Medicaid. The cost of these components could easily match the available funding.

Conditional on seeking and receiving federal approval for a state innovation waiver, the bill may result in an additional revenue gain starting in FY 23 or later. Generally, state innovation waiver programs generate new state revenue from the federal government (known as "pass-through" funding) that can be used to partially fund the initiative. The amount is based on how much the program reduces federal premium tax credits for Connecticut exchange enrollees.[1] Any such

[1]For example, research by Wakely Consulting Group, LLC. conducted for the exchange in February 2020 estimated that a reinsurance program under a state innovation waiver with a state investment of $19.5 million could generate $23 million or more in federal pass-through funding.

revenue would be received annually while the waiver was in effect.

The bill requires pharmaceutical manufacturers that violated the pricing provisions during the previous calendar year to annually pay the Department of Revenue Services (DRS) commissioner the civil penalty the bill imposes. This results in: 1) a potential revenue gain to the Covered Connecticut account beginning in FY 23, and 2) a one-time cost of less than $100,000 in FY 23 associated with tax form development, postage costs, and associated updates to the online Taxpayer Service Center.

It is unclear how violations of the bill's provisions by pharmaceutical manufacturers would be determined. To the extent the DRS is required to monitor pharmaceutical company sales and investigate potential violations, there is a cost to the agency beginning as early as FY 22. Any potential cost is anticipated to be less than $500,000 annually.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the fines and penalties assessed, the design of the annual OHS plan and its approval, including the number of any newly eligible individuals and associated costs under any expansion of Medicaid eligibility, and the actual amount of federal premium tax credit savings achieved under any federally approved state innovation waiver.

OLR Bill Analysis

sHB 6447

AN ACT CREATING THE COVERED CONNECTICUT PROGRAM TO EXPAND ACCESS TO AFFORDABLE HEALTH CARE.

SUMMARY

This bill requires the Office of Health Strategy (OHS), in consultation with Access Health CT and the Department of Social Services (DSS) and insurance commissioners, to create a plan to reduce the state's uninsured rate, including by reducing the burden of health care costs on insureds. The plan requires annual legislative approval, starting by February 1, 2022.

The bill establishes the Covered Connecticut Account as a separate, nonlapsing account within the General Fund. OHS administers the account, which must contain any money required by law to be deposited into it. This includes (1) an annual assessment the bill imposes on insurers that is proportional to their covered lives in Connecticut and (2) fines paid by pharmaceutical manufacturers for selling a prescription drug for a price higher than the bill allows. The bill sets the aggregate amount of fees assessed on insurers in the first year at $30 million, but potentially exempts nondomestic insurers from the assessment if other states impose retaliatory taxes on entities domiciled in Connecticut.

Funds in the account must be spent by Access Health CT and DSS according to the annual plan described above.

The bill prohibits pharmaceutical manufacturers from selling a prescription drug for a price higher than the drug's reference price (i.e., the drug's wholesale acquisition cost) adjusted for changes in the consumer price index for urban consumers, plus 2% of the reference price per year compounded annually on the anniversary of the date the drug was first commercially marketed.

Under the bill, pharmaceutical manufacturers who violate the price limit are liable to the state for a civil penalty of 80% of the increased revenue the pharmaceutical manufacturer earned by selling the drug higher than allowed. It also establishes procedures and due process for reporting, collecting, and contesting the penalty.

The bill also subjects pharmaceutical manufacturers to a $500,000 civil penalty if they withdraw a drug from the Connecticut market (a) without giving advance written notice or (b) to avoid paying the civil penalty for selling a drug above the price limit.

It exempts (1) from the price limitations, drugs the Health and Human Services (HHS) secretary determines are in shortage in the United States and (2) from the civil penalty, pharmaceutical manufacturers making less than $250,000 in annual sales in Connecticut in the calendar year the penalty would be imposed.

EFFECTIVE DATE: July 1, 2021

§§ 1-4 — COVERED CONNECTICUT PROGRAM

The bill requires OHS to develop the plan in consultation with Access Health CT and the DSS and insurance commissioners. The plan may call for Access Health CT to:

1. establish a program to provide health insurance premium subsidies at defined amounts to individuals in defined income brackets up to and including 600% of the federal poverty level ($131,760 for a family of 3, in 2021);

2. establish a reinsurance program; or

3. in consultation with OHS, seek a federal Section 1332 state innovation waiver, and implement it if approved (a 1332 waiver allows a state to waive certain federal requirements that might otherwise prohibit it from implementing certain programs).

The plan may also call for the DSS commissioner to expand eligibility for medical assistance programs (e.g., Medicaid).

Legislative Approval

Beginning by January 1, 2022, OHS must annually submit a report on the plan to the Insurance and Real Estate Committee. Beginning by February 1, 2022, the committee must annually advise OHS, Access Health CT, and the DSS and insurance commissioners on its approval or rejection of the plan. If the committee does not act by February 1 annually, the plan is rejected.

§ 4 — COVERED CONNECTICUT INSURER ASSESSMENT

Determination of Amount

The bill requires OHS, starting by July 1, 2022, to annually calculate the difference between $50 million and the total amount of civil penalties that pharmaceutical manufacturers paid under the bill. The result is the aggregate amount for which insurers and HMOs will be assessed. But for the 2022 calendar year, the bill requires OHS, by July 1, 2021, to report the result as $30 million (thus, making the initial aggregate assessment $30 million).

Assessment

The bill requires the insurance commissioner to annually assess insurers and HMOs doing business in Connecticut, including exempt insurers (i.e., insurers that administer self-insured health benefit plans and are exempt from third-party administrator licensure), a fee proportionate to their covered lives that is sufficient to fully meet the aggregate assessment amount reported above. This money is deposited into the Covered Connecticut account.

Covered Lives Reporting. Beginning July 1, 2021, each insurer, HMO, and exempt insurer must annually report to the commissioner, in a form and manner he prescribes, the number of enrolled or insured lives in the state that are covered by certain health insurance plans as of the preceding May 1. The number must exclude any individuals covered by fully-insured plans sold in the small group market, Medicare, any DSS medical assistance program, Medicare Part C plans, or workers' compensation insurance.

This requirement applies to health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

Beginning by August 1, 2021, the commissioner must annually:

1. determine the fee using a factor that is based on the amount of covered lives reported to him in July and the aggregate assessment amount OHS determines and

2. submit a proposed fee statement to each insurer and HMO, which must pay the assessed fee by November 1 of that year.

Insurers and HMOs who fail to file the report of covered lives or pay the assessment must pay a late filing or payment fee, as applicable, of $100 per day from the date the report or fee was due.

The bill authorizes the insurance commissioner to require insurers and HMOs to produce any supporting documents used to prepare the report. If the commissioner determines there is anything other than a good faith discrepancy between the actual and reported number of covered lives, he must impose a civil penalty of up to $15,000 for each report with a discrepancy.

Grievances and Overpayments. An aggrieved insurer may appeal the assessment in the same manner that existing law allows for other insurance assessments, which includes appealing to the New Britain Superior Court (CGS § 38a-52).

The bill requires the insurance commissioner to apply an overpayment of the assessment as a credit against the next year's fee if (1) the overpayment is more than $5,000 and (2) by April 1 of that year, the insurer or HMO notifies the commissioner about the overpayment and provides sufficient supporting evidence.

Within 90 days after receiving the notice and supporting evidence, the insurance commissioner must determine if an overpayment

occurred and notify the payor of his determination.

Insurers who fail to notify the commissioner within this timeframe, waive their right to an overpayment refund. However, this does not prohibit or limit their rights to appeal the assessment under existing law or the bill's provisions.

Retaliatory Taxes

The bill establishes circumstances under which nondomestic insurers (i.e., insurers domiciled outside of Connecticut) may be exempt from the Covered Connecticut assessment. Under the bill, if another jurisdiction imposes a retaliatory fee on a Connecticut-domiciled insurer, fraternal benefit society, hospital or medical service corporation, HMO, or other entity, it may appeal to the Connecticut insurance commissioner within 60 days for a verification that the Covered Connecticut assessment is causing a retaliatory fee. If the commissioner verifies that the fee is retaliatory, he must exempt nondomestic insurers and nondomestic exempt insurers from the Covered Connecticut assessment.

These decisions can be appealed in the same manner as assessments under existing law, as described above.

Implementing Regulations

The bill authorizes the commissioner to adopt implementing regulations.

§§ 1 & 6-8 — PHARMACEUTICAL MANUFACTURER PRICING LIMITS

Beginning January 1, 2022, the bill prohibits pharmaceutical manufacturers from selling a prescription drug for more than:

1. the drug's reference price, adjusted for any change in the consumer price index for urban consumers, plus

2. 2% for each 12-month period since the date the reference price was determined, compounded annually on the anniversary of that date.

Under the bill, a "pharmaceutical manufacturer" is anyone manufacturing and selling a prescription drug, either directly or through another person, for distribution in Connecticut. A drug's "reference price" is the drug's wholesale acquisition cost as of January 1, 2021, or for new drugs, the date when it is first commercially marketed in the United States. A drug's "wholesale acquisition cost" is generally the manufacturer's list price for the drug to wholesalers or direct purchasers in the United States, excluding discounts, rebates, or reductions, for the most recent month for which data is available.

The bill requires OHS, beginning by February 1, 2023, to annually provide the Department of Revenue Services (DRS) commissioner with a list of drugs the HHS secretary determines are in shortage. These drugs are exempt from the above provisions on pricing limitations.

Civil Penalty

Under the bill, a pharmaceutical manufacturer selling a prescription drug above the price limit is subject to a civil penalty, determined and collected on a calendar year basis. The penalty equals 80% of the increased revenue the pharmaceutical company made by selling the drug at the higher price compared to a price allowed under the bill.

Under the bill, all money collected from the civil penalty must be deposited into the Covered Connecticut account. The penalties are deemed a civil fine or penalty under federal law (thus excluding them from state tax revenue for certain federal benefit calculations) and cannot be waived by the Revenue Services Penalty Review Committee or under any other applicable law. Additionally, the bill prohibits tax credits from being applied towards the penalty.

Penalty Payment Provisions. Beginning March 1, 2023, the bill requires pharmaceutical manufacturers that violated the pricing provisions during the previous calendar year to annually pay the DRS commissioner the civil penalty the bill imposes.

They must also file with the DRS commissioner a statement containing information in a form and manner he prescribes. The

statement and civil penalty must be electronically filed and paid, regardless of how the manufacturer would have otherwise filed with, or paid money to, DRS. If no statement is filed by the due date, the bill authorizes the commissioner to make the statement at any time after the due date according to the best obtainable information and prescribed form.

Tax Warrants and Liens. The bill allows the civil penalty to be collected in accordance with existing law that authorizes DRS and other state collection agencies to: (1) issue a tax warrant on the intangible personal property (e.g., bank accounts, receivables, and securities) of a taxpayer who fails to pay state taxes and (2) serve the warrant on a third party (e.g., bank or payment settlement entity) who possesses the property or is obligated to it in some way (CGS § 12-35). Under the bill, the warrant must be signed by the DRS commissioner or his authorized agent.

Additionally, the amount of the civil penalty becomes a lien on the pharmaceutical manufacturer's real property, beginning on the last day of the month before the penalty was due, until it is paid. The commissioner may record the lien in the records of the town in which the manufacturer is located, but the bill prohibits the lien from being enforced against a bona fide purchaser or qualified encumbrancer of the property. If the lien is satisfied, the commissioner must discharge it upon request from an interested party.

The bill allows the (1) attorney general to bring a foreclosure action against the lien in the Superior Court in the judicial district where the property is located and (2) court to make any order it deems equitable.

It also applies existing laws on collecting taxes and related penalties from taxpayers to the civil penalties imposed under the bill.

Examination Authority and Record Keeping. If a pharmaceutical manufacturer is subject to the civil penalty, the bill authorizes the DRS commissioner to examine its books and determine if it paid the full penalty amount. If the commissioner determines that it did not, he must

bill the pharmaceutical manufacturer for the full amount. The commissioner, or any person he authorizes, may additionally examine the books, papers, records, and equipment of anyone liable for the civil penalty, and investigate the character of their business to verify the accuracy of the filed statement (or if no statement is filed, to ascertain and determine the civil penalty amount).

The bill authorizes the commissioner to require all pharmaceutical manufacturers subject to a civil penalty to keep any records he prescribes and produce books, papers, documents, and other data he needs to determine the penalty amount and collect it.

The bill grants the commissioner and his agents the power to administer oaths and take testimony under oath in matters related to an inquiry or investigation.

Requests for a Hearing and Reduction. Under the bill, an aggrieved pharmaceutical manufacturer may apply in writing to the commissioner for a hearing, laying out why a hearing should be granted and how much the civil penalty should be. The pharmaceutical manufacturer must apply within 60 days after receiving the penalty notice or after it is delivered or mailed to the manufacturer. The commissioner may also order a hearing on his own initiative.

The commissioner must promptly consider and either grant or deny each application. If he denies it, he must immediately notify the applicant; if he approves it, he must provide the hearing date, time, and place. Following the hearing, he must provide the applicant a copy of any order he makes.

Additionally, the bill allows him to require a pharmaceutical manufacturer or any other person he believes possesses relevant information to appear, along with any specified documents for examination under oath.

In any hearing, the bill allows the commissioner or his authorized agents to subpoena witnesses and require the production of books,

papers, and documents related to the investigation. A witness may not be excused from testifying or from producing documents solely because doing so would incriminate him or her. However, the bill prevents such evidence from being used in a criminal proceeding against the witness.

The bill allows the commissioner to apply to the Superior Court that has jurisdiction over the pharmaceutical manufacturer being investigated, or another court of competent jurisdiction, to compel any person to obey a subpoena. The bill requires the court to commit an individual still disobeying a subpoena or summons to a community correctional center until they do so, for up to a maximum of 60 days.

The bill requires that officers serving subpoenas and witnesses attending hearings receive fees and compensation at the same rate as they would for appearing in court.

Appeals. Any pharmaceutical manufacturer aggrieved by the commissioner's orders, decisions, determinations, or disallowances may appeal, within 30 days after receiving notice of the commissioner's action, to the Superior Court for the New Britain judicial district. The appeal must be accompanied by a citation to the commissioner to appear. It must be signed, served, and returned in the same way existing law requires for a civil summons in a civil action.

The authority issuing the citation must take from the person appealing the case, a bond or recognizance, with surety, to prosecute the appeal to effect and to comply with the court orders and decrees. These appeals must be preferred cases, to be heard at the first session of the court or an appointed committee, unless cause appears to the contrary.

Under the bill, the court may grant equitable relief, and if the civil penalty has already been paid, may order the treasurer to refund it. If the appeal has been taken without probable cause, the court may tax double or triple costs, as the case demands. After an appeal is denied, the court may, at its discretion, tax the manufacturer the costs of the appeal, but no costs must be taxed against the state.

Officer or Employee Penalties

Under the bill, a pharmaceutical manufacturer officer or employee who owes a duty to pay a civil penalty, file statements, or keep or produce records under the bill's provisions and willfully fails to do so is subject to a fine up to $1,000, up to a year in prison, or both. Regardless of other state law, the bill establishes a three-year statute of limitations for officers or employees to be prosecuted after each violation.

Additionally, any officer or employee who willfully delivers or discloses any false list, statement, return, account statement, or other document to the commissioner is guilty of a class D felony, punishable by a fine up to $5,000, up to 5 years in prison, or both.

The bill prohibits an officer or employee from being charged with an offense under both the provisions described above in connection with the same civil penalty. However, it allows the officer or employee to be charged for both offenses upon the same information.

List of Offenders

Beginning by July 1, 2023, the bill requires the commissioner to annually prepare, and make publicly available, a list of each pharmaceutical manufacturer that violated the bill's provisions during the preceding year.

Implementing Regulations

The bill authorizes the DRS commissioner to adopt implementing regulations.

Pharmaceutical Manufacturer's Withdrawing Prescription Drugs (§ 8)

Additionally, the bill prohibits a pharmaceutical manufacturer from withdrawing a prescription drug in Connecticut after it has been identified as being sold above the bill's price limits to avoid the civil penalty. Pharmaceutical manufacturers must notify OHS in writing at least 180 days before withdrawing one of these drugs from the Connecticut market. Under the bill, a pharmaceutical manufacturer that violates either of these provisions is subject to a $500,000 civil penalty.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 14 Nay 4 (03/22/2021)