General Assembly

Governor's Bill No. 6447

January Session, 2021

LCO No. **3294**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
Request of the Governor Pursuant
to Joint Rule 9

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:

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2 statutes are repealed and the following is substituted in lieu thereof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

4 (a) There is established an Office of Health Strategy, which shall be
5 within the Department of Public Health for administrative purposes
6 only. The department head of said office shall be the executive director
7 of the Office of Health Strategy, who shall be appointed by the Governor
8 in accordance with the provisions of sections 4-5 to 4-8, inclusive, with
9 the powers and duties therein prescribed.

10 (b) The Office of Health Strategy shall be responsible for the
11 following:

12 (1) Developing and implementing a comprehensive and cohesive
13 health care vision for the state, including, but not limited to, a
14 coordinated state health care cost containment strategy;

15 (2) Promoting effective health planning and the provision of quality
16 health care in the state in a manner that ensures access for all state
17 residents to cost-effective health care services, avoids the duplication of
18 such services and improves the availability and financial stability of
19 such services throughout the state;

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

22 (4) (A) Coordinating the state's health information technology
23 initiatives, (B) seeking funding for and overseeing the planning,
24 implementation and development of policies and procedures for the
25 administration of the all-payer claims database program established
26 under section 19a-775a, (C) establishing and maintaining a consumer
27 health information Internet web site under section 19a-755b, and (D)
28 designating an unclassified individual from the office to perform the
29 duties of a health information technology officer as set forth in sections
30 17b-59f and 17b-59g;

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

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

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

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

43 (9) Annually (A) developing a plan, pursuant to subsection (b) of
44 section 3 of this act, in consultation with the Connecticut Health

45 Insurance Exchange, Commissioner of Social Services and Insurance
46 Commissioner, and (B) submitting a report, pursuant to subsection (c)
47 of section 3 of this act and in accordance with section 11-4a, to the joint
48 standing committee of the General Assembly having cognizance of
49 matters relating to insurance; and

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

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

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

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

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

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

74 (4) "Office of Health Strategy" means the Office of Health Strategy

75 established under section 19a-754a of the general statutes, as amended
76 by this act; and

77 (5) "Qualified health plan" has the same meaning as provided in
78 section 38a-1080 of the general statutes.

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

86 (1) The exchange to:

87 (A) Establish:

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

92 (ii) A reinsurance program; or

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

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

99 (c) Not later than January 1, 2022, and annually thereafter, the Office
100 of Health Strategy shall submit a report, in accordance with section 11-
101 4a of the general statutes, to the joint standing committee of the General
102 Assembly having cognizance of matters relating to insurance. Such
103 report shall contain the plan developed pursuant to subsection (b) of

104 this section.

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

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

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

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

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

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

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

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

127 (c) (1) Each insurer and health care center doing health insurance
128 business in this state, and each exempt insurer, shall annually pay to the
129 Insurance Commissioner, for deposit in the Covered Connecticut
130 account, a fee assessed by the commissioner pursuant to this section.

131 (2) Not later than July 1, 2021, and annually thereafter, each insurer,

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

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

157 (4) (A) Not later than August 1, 2021, and annually thereafter, the
158 commissioner shall submit a statement to each insurer, health care
159 center and exempt insurer described in subdivision (1) of this subsection
160 that includes the proposed fee imposed under this section for such
161 insurer, health care center or exempt insurer determined in accordance
162 with this subsection. Each such insurer, health care center and exempt
163 insurer shall pay such fee to the commissioner not later than November
164 first of that year.

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

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

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

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

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

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

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

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

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

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

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

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

216 (d) If another state, territory or district of the United States, or a
217 foreign country, imposes on a Connecticut domiciled insurer, fraternal
218 benefit society, hospital service corporation, medical service
219 corporation, health care center or other domestic entity a retaliatory
220 charge for the fee imposed under this section, such domestic entity may,
221 not later than sixty days after receipt of notice of the imposition of the
222 retaliatory charge for such fee, appeal to the Insurance Commissioner
223 for a verification that the fee imposed under this section is subject to
224 retaliation by another state, territory or district of the United States, or a
225 foreign country. If the commissioner verifies, upon appeal to and
226 certification by the commissioner, that the fee imposed under this

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

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

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

241 The exchange shall:

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

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

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

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

252 (5) Provide for enrollment periods, as provided under Section
253 1311(c)(6) of the Affordable Care Act;

254 (6) Maintain an Internet web site through which enrollees and
255 prospective enrollees of qualified health plans may obtain standardized

256 comparative information on such plans including, but not limited to, the
257 enrollee satisfaction survey information under Section 1311(c)(4) of the
258 Affordable Care Act and any other information or tools to assist
259 enrollees and prospective enrollees evaluate qualified health plans
260 offered through the exchange;

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

265 (8) On or before the open enrollment period for plan year 2017, assign
266 a rating to each qualified health plan offered through the exchange in
267 accordance with the criteria developed by the Secretary under Section
268 1311(c)(3) of the Affordable Care Act, and determine each qualified
269 health plan's level of coverage in accordance with regulations issued by
270 the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

271 (9) Use a standardized format for presenting health benefit options in
272 the exchange, including the use of the uniform outline of coverage
273 established under Section 2715 of the Public Health Service Act, 42 USC
274 300gg-15, as amended from time to time;

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

284 (11) Collaborate with the Department of Social Services, to the extent
285 possible, to allow an enrollee who loses premium tax credit eligibility
286 under Section 36B of the Internal Revenue Code and is eligible for
287 HUSKY A or any other state or local public program, to remain enrolled

288 in a qualified health plan;

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

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

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

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

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

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

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

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

316 (B) The name and taxpayer identification number of each individual

317 who was an employee of an employer but who was determined to be
318 eligible for the premium tax credit under Section 36B of the Internal
319 Revenue Code because:

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

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

326 (C) The name and taxpayer identification number of:

327 (i) Each individual who notifies the exchange under Section
328 1411(b)(4) of the Affordable Care Act that such individual has changed
329 employers; and

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

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

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

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

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

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

349 (C) Facilitate enrollment in qualified health plans;

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

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

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

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

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

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

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

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

379 (D) The Department of Social Services; and

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

381 (23) Meet the following financial integrity requirements:

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

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

390 (i) Investigate the affairs of the exchange;

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

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

394 (C) Not use any funds in carrying out its activities under sections 38a-
395 1080 to 38a-1089, inclusive, that are intended for the administrative and
396 operational expenses of the exchange, for staff retreats, promotional
397 giveaways, excessive executive compensation or promotion of federal
398 or state legislative and regulatory modifications;

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

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

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

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

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

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

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

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

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

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

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

446 (5) "Legend drug" has the same meaning as provided in section 20-
447 571 of the general statutes;

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

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

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

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

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

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

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

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

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

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

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

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

491 (B) The revenue that the pharmaceutical manufacturer would have
492 earned from all sales of the identified prescription drug in this state

493 during the calendar year if the pharmaceutical manufacturer had sold
494 such identified prescription drug at a price that did not exceed the
495 amount described in subsection (a) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

624 (i) The amount of any civil penalty unpaid under the provisions this
625 section may be collected under the provisions of section 12-35 of the
626 general statutes. The warrant provided under section 12-35 of the
627 general statutes shall be signed by the commissioner or the
628 commissioner's authorized agent. The amount of any such civil penalty
629 shall be a lien on the real property of the pharmaceutical manufacturer
630 from the last day of the month next preceding the due date of such civil
631 penalty until such civil penalty is paid. The commissioner may record
632 such lien in the records of any town in which the real property of such
633 pharmaceutical manufacturer is situated, but no such lien shall be
634 enforceable against a bona fide purchaser or qualified encumbrancer of
635 such real property. When any civil penalty with respect to which a lien
636 has been recorded under the provisions of this subsection has been
637 satisfied, the commissioner shall, upon request of any interested party,
638 issue a certificate discharging such lien, which certificate shall be
639 recorded in the same office in which such lien was recorded. Any action
640 for the foreclosure of such lien shall be brought by the Attorney General
641 in the name of this state in the Superior Court for the judicial district in
642 which the real property subject to such lien is situated, or, if such
643 property is located in two or more judicial districts, in the Superior
644 Court for any one such judicial district, and the court may limit the time
645 for redemption or order the sale of such real property or make such
646 other or further decree as it judges equitable. The provisions of section
647 12-39g of the general statutes shall apply to all civil penalties imposed
648 under this section.

649 (j) (1) Any officer or employee of a pharmaceutical manufacturer who
650 owes a duty to the pharmaceutical manufacturer to pay a civil penalty
651 imposed under this section on behalf of such pharmaceutical
652 manufacturer, file a statement with the commissioner pursuant to
653 subsection (c) of this section on behalf of such pharmaceutical
654 manufacturer, keep records or supply information to the commissioner
655 on behalf of such pharmaceutical manufacturer pursuant to this section
656 and wilfully fails, at the time required under this section, to pay such
657 civil penalty, file such statement, keep such records or supply such

658 information on behalf of such pharmaceutical manufacturer shall, in
659 addition to any other penalty provided by law, be fined not more than
660 one thousand dollars or imprisoned not more than one year, or both.
661 Notwithstanding the provisions of section 54-193 of the general statutes,
662 no such officer or employee shall be prosecuted for a violation of the
663 provisions of this subdivision committed on or after July 1, 2021, except
664 within three years next after such violation has been committed.

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

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

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

688 (l) Not later than July 1, 2023, and annually thereafter, the
689 commissioner shall prepare a list containing the name of each

690 pharmaceutical manufacturer that violated subsection (a) of this section
691 during the preceding calendar year. The commissioner shall make each
692 list publicly available.

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

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

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

706 (c) Any pharmaceutical manufacturer that violates any provision of
707 subsection (a) or (b) of this section shall be liable to this state for a civil
708 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 Purpose:
To implement the Governor's budget recommendations.

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