General Assembly

Amendment

February Session, 2022

LCO No. **6502**

Offered by:
SEN. LESSER, 9th Dist.
SEN. KELLY, 21st Dist.
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To: Subst. Senate Bill No. **13** File No. 208 Cal. No. 164

"AN ACT REDUCING PRESCRIPTION DRUG PRICES."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective July 1, 2022*) For the purposes of this section and sections 2 to 6, inclusive, of this act unless the context otherwise requires:

(1) "Commissioner" means the Commissioner of Consumer Protection;

(2) "Drug" means an article that is (A) recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement thereto, (B) intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans, (C) not food and intended to affect the structure or any function of the human body, and (D) not a device and

intended for use as a component of any other article specified in subparagraphs (A) to (C), inclusive, of this subdivision;

(3) "Drug Quality and Security Act" means the Drug Quality and Security Act, 21 USC 351, et seq., as amended from time to time;

(4) "Food, Drug and Cosmetic Act" means the Food, Drug and Cosmetic Act, 21 USC 301, et seq., as amended by the Drug Quality and Security Act, as both may be amended from time to time;

(5) "Importation program" means the Canadian legend drug importation program established by the commissioner pursuant to section 2 of this act;

(6) "Institutional pharmacy" has the same meaning as provided in section 20-571 of the general statutes;

(7) "Laboratory testing" means a quantitative and qualitative analysis of a prescription drug consistent with the official United States Pharmacopoeia;

(8) "Legend drug" means a drug that (A) any applicable federal or state law provides shall only be (i) dispensed pursuant to a prescription, or (ii) used by a prescribing practitioner, or (B) applicable federal law requires to bear the following legend: "RX ONLY" IN ACCORDANCE WITH GUIDELINES ESTABLISHED IN THE FEDERAL FOOD, DRUG AND COSMETIC ACT;

(9) "Manufacturer" means (A) an applicant as defined in 21 CFR 314.3, as amended from time to time, (B) a person who owns or operates an establishment that manufactures an eligible prescription drug, or (C) a holder of a drug master file containing information necessary to conduct the Statutory Testing, prepare the manufacturer's attestation and information statement, or comply with Section 804 of the Food, Drug and Cosmetic Act, 21 USC 360(b), as amended from time to time;

(10) "Participating Canadian supplier" means a manufacturer or wholesale drug distributor within Canada that (A) holds an active Drug

Establishment License to wholesale drugs by Health Canada, (B) is registered with provincial regulatory authorities to distribute HPFB-approved drugs, (C) is not licensed by a provincial regulatory authority with an international pharmacy license that allows it to distribute drugs that are approved by countries other than Canada and that are not HPFB-approved for distribution in Canada, (D) is properly registered, if such Canadian supplier is required to be registered, with the United States Food and Drug Administration, or any successor agency, and (E) exports legend drugs, in the manufacturer's original container, to a participating wholesaler for distribution in this state under the importation program;

(11) "Participating wholesaler" means a wholesaler as defined in 21 CFR 251.2, as amended from time to time, that is designated by the commissioner to participate in the importation program in this state. Participating wholesaler does not include a person authorized to import drugs under Section 801 (d) (1) of the Food, Drug and Cosmetic Act, 21 USC 381, as amended from time to time;

(12) "Pharmacy" has the same meaning as provided in section 20-571 of the general statutes;

(13) "Prescription" means a lawful oral, written or electronic order by a prescribing practitioner for a drug for a specific patient;

(14) "Qualified laboratory" means a laboratory in this state that has been approved by the United States Food and Drug Administration for the purposes of Section 804 of the Food, Drug and Cosmetic Act, 21 USC 360(b), as amended from time to time;

(15) "Qualified wholesaler" means a wholesaler, as defined in section 21a-70 of the general statutes, that has received a certificate of registration from the commissioner pursuant to said section; and

(16) "Track-and-trace" means the product tracing process for the components of the pharmaceutical distribution supply chain, as described in Title II of the Drug Quality and Security Act.

Sec. 2. (NEW) (*Effective July 1, 2022*) (a) The commissioner shall establish a program to be known as the "Canadian legend drug importation program". Under such importation program, the commissioner shall, notwithstanding any provision of the general statutes:

(1) Provide for the importation from Canada of safe and effective legend drugs that have the highest potential for cost savings for patients in this state;

(2) Develop and implement an application and approval process for qualified wholesalers to be designated as participating wholesalers; and

(3) Designate one or more participating wholesalers to distribute in this state legend drugs, imported from Canada, from a participating Canadian supplier and in the manufacturer's original container, to a licensed pharmacy or institutional pharmacy or a qualified laboratory.

(b) (1) Not later than July 1, 2023, the commissioner shall submit a request to the federal Secretary of Health and Human Services seeking approval for the importation program under 21 USC 384, as amended from time to time. Such request shall, at a minimum:

(A) Describe the commissioner's plans for operating the importation program;

(B) Demonstrate that the legend drugs to be imported and distributed in this state under the importation program shall:

(i) Meet all applicable federal and state standards for safety and effectiveness; and

(ii) Comply with all federal tracing procedures and federal supply chain security requirements as set forth in 21 CFR 251.14, as amended from time to time;

(C) Disclose the costs of implementing the importation program;

(D) Meet all review and authorization criteria as set forth in 21 CFR 251.4, as amended from time to time; and

(E) Satisfy all pre-importation requirements as set forth in 21 CFR 251.5.

(2) (A) If the federal Secretary of Health and Human Services approves the commissioner's request, the commissioner shall:

(i) Submit to (I) the Commissioner of Public Health a notice disclosing that the federal Secretary of Health and Human Services has approved such request, and (II) the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, general law, human services, insurance and public health a notice disclosing that the federal Secretary of Health and Human Services has approved such request; and

(ii) Begin operating the importation program not later than one hundred eighty days after the date of such approval.

(B) Except as otherwise provided in this subsection, the commissioner shall not operate the importation program unless the federal Secretary of Health and Human Services approves the commissioner's request.

Sec. 3. (NEW) (*Effective July 1, 2022*) (a) Each participating wholesaler may, subject to the provisions of this section and sections 2 and 5 of this act, import into this state a legend drug from a participating Canadian supplier, and distribute such legend drug to a licensed pharmacy or institutional pharmacy, or a qualified laboratory in this state, under the importation program if:

(1) Such participating wholesaler:

(A) Is registered with the federal Secretary of Health and Human Services pursuant to 21 CFR 251, as amended from time to time; and

(B) Holds a valid labeler code that was issued to such participating

wholesaler by the United States Food and Drug Administration, or any successor agency; and

(2) Such legend drug:

(A) May be imported into this state in accordance with applicable federal patent laws;

(B) Meets the United States Food and Drug Administration's, or any successor agency's, standards concerning drug safety, effectiveness, misbranding and adulteration; and

(C) Is not:

(i) A controlled substance, as defined in 21 USC 802, as amended from time to time;

(ii) A biological product, as defined in 42 USC 262, as amended from time to time;

(iii) An infused drug;

(iv) An intravenously, intradermally, intrathecally, intramuscularly or subcutaneously injected drug;

(v) A drug that is inhaled during surgery;

(vi) A drug that is a parenteral drug, the importation of which is determined by the federal Secretary of Health and Human Services to pose a threat to the public health; or

(vii) A drug that is a compound which is not commercially available.

(b) Each participating wholesaler shall:

(1) Comply with all applicable track-and-trace requirements, and make available to the commissioner all track-and-trace records not later than forty-eight hours after said commissioner requests such records;

(2) Not import into, or distribute, dispense or sell, in this state any

legend drugs under the importation program except in accordance with the provisions of this section and sections 2 and 5 of this act;

(3) Not distribute, dispense or sell outside of this state any legend drugs that are imported into this state under the importation program;

(4) Ensure the safety and quality of each legend drug that is imported and distributed in this state under the importation program;

(5) Comply with federal pre-importation request requirements as set forth in 21 CFR 251.5, as amended from time to time;

(6) For each initial shipment of any legend drug that is imported into this state by such participating wholesaler, ensure that a qualified laboratory engaged by such participating wholesaler tests a statistically valid sample size for each batch of such legend drug in such shipment for authenticity and degradation in a manner that is consistent with the Food, Drug and Cosmetic Act and 21 CFR 251.16, as both may be amended from time to time;

(7) For each subsequent shipment of a legend drug that is imported into this state by such participating wholesaler, and sampled and tested pursuant to subdivision (6) of this subsection, ensure that a qualified laboratory engaged by such participating wholesaler tests a statistically valid sample of such legend drug in such shipment for authenticity and degradation in a manner that is consistent with the Food, Drug and Cosmetic Act and 21 CFR 251.16, as both may be amended from time to time, and quarantine such shipment until the results of such test conducted pursuant to this subdivision indicate that such legend drug is consistent with its labeling;

(8) Certify to the commissioner that each legend drug imported into this state under the importation program:

(A) Is approved for marketing in the United States and not adulterated or misbranded;

(B) Meets all labeling requirements under 21 USC 352, as amended

from time to time;

(C) Meets all labeling requirements as set forth in 21 CFR 251.12, 21 CFR 251.13 and 21 CFR 251.14, as amended from time to time;

(9) Either:

(A) Propose a national drug code for each drug imported into this state in accordance with sections 1 to 6, inclusive, of this act, pursuant to the procedures under 21 CFR 207.33, as amended from time to time, and list such drug pursuant to the procedures set forth in 21 CFR 207.53, as amended from time to time; or

(B) Ensure that the entity performing relabeling on such wholesaler's behalf lists each eligible prescription drug and incorporates the national drug code such wholesaler proposed for assignment in accordance with the labeling requirements set forth in 21 CFR 207, as amended from time to time;

(10) Maintain laboratory records, including, but not limited to, complete data derived from all tests necessary to ensure that each legend drug imported into this state under the importation program satisfies the requirements of subdivisions (6) and (7) of this subsection;

(11) Maintain documentation demonstrating that the testing required by subdivisions (6) and (7) of this subsection was conducted at a qualified laboratory in accordance with the Food, Drug and Cosmetic Act and all other applicable federal and state laws and regulations concerning laboratory qualifications;

(12) Maintain the following information for each legend drug that such participating wholesaler imports and distributes in this state under the importation program, and submit such information to the commissioner upon request by the commissioner:

(A) The name and quantity of the active ingredient of such legend drug;

(B) A description of the dosage form of such legend drug;

(C) The date on which such participating wholesaler received such legend drug;

(D) The quantity of such legend drug that such participating wholesaler received;

(E) The point of origin and destination of such legend drug;

(F) The price paid by such participating wholesaler for such legend drug;

(G) A report for each legend drug that fails laboratory testing under subdivision (6) or (7) of this subsection; and

(H) Such additional information and documentation that the commissioner deems necessary to ensure the protection of the public health;

(13) Ensure that any legend drug that fails laboratory testing under subdivision (6) or (7) of this subsection is appropriately quarantined and destroyed; and

(14) Maintain all information and documentation that is submitted to the commissioner pursuant to this subsection for a period of not less than three years.

Sec. 4. (NEW) (*Effective July 1, 2022*) Each participating Canadian supplier shall:

(1) Comply with all applicable track-and-trace requirements;

(2) Not distribute, dispense or sell outside of this state any legend drugs that are imported into this state under the importation program; and

(3) Maintain the following information and documentation and, upon request by the commissioner, submit such information and

documentation to the commissioner for each legend drug that such participating Canadian supplier exports into this state under the importation program:

(A) The original source of such legend drug, including, but not limited to:

(i) The name of the manufacturer of such legend drug;

(ii) The date on which such legend drug was manufactured; and

(iii) The location where such legend drug was manufactured;

(B) The date on which such legend drug was shipped to a participating wholesaler;

(C) The quantity of such legend drug that was shipped to a participating wholesaler;

(D) The quantity of each lot of such legend drug that such participating Canadian supplier originally received and the source of such lot;

(E) The lot or control number and the batch number assigned to such legend drug by the manufacturer; and

(F) Such additional information and documentation that the commissioner deems necessary to ensure the protection of the public health.

Sec. 5. (NEW) (*Effective July 1, 2022*) (a) The commissioner shall issue a written order:

(1) Suspending importation and distribution of a legend drug under the importation program if the commissioner discovers that such importation or distribution violates any provision of sections 2 to 4, inclusive, of this act or any other applicable state or federal law or regulation, including post importation requirements as set forth in 21 CFR 251.18;

(2) Suspending all importation and distribution of legend drugs by a participating wholesaler under the importation program if the commissioner discovers that the participating wholesaler has violated any provision of section 2 or 3 of this act or any other applicable state or federal law or regulation;

(3) Suspending all importation and distribution of legend drugs by a participating Canadian supplier under the importation program if the commissioner discovers that the participating Canadian supplier has violated any provision of section 2 or 4 of this act or any other applicable state or federal law or regulation;

(4) Requiring the quarantine, recall or seizure of any legend drug that was imported and distributed under the importation program if such legend drug has been identified as adulterated, within the meaning of section 21a-105 of the general statutes, or misbranded; or

(5) Requiring retesting, at the expense of the participating wholesaler and by a laboratory approved by the commissioner, of any legend drug distributed by the participating wholesaler if the commissioner deems such retesting necessary.

(b) The commissioner shall send a notice to each participating Canadian supplier and participating wholesaler affected by an order issued pursuant to subsection (a) of this section notifying such participating Canadian supplier or participating wholesaler that:

(1) The commissioner has issued such order, and providing the legal and factual basis for such order; and

(2) Such participating Canadian supplier or participating wholesaler may request, in writing, a hearing before the commissioner, provided such request is received by the commissioner not later than thirty days after the date of such notice.

(c) If a participating Canadian supplier or participating wholesaler timely requests a hearing pursuant to subsection (b) of this section, the

commissioner shall, not later than thirty days after the receipt of the request, convene the hearing as a contested case in accordance with the provisions of chapter 54 of the general statutes. Not later than sixty days after the receipt of such request, the commissioner shall issue a final decision vacating, modifying or affirming the commissioner's order. If the participating Canadian supplier or participating wholesaler is aggrieved by such final decision, such participating Canadian supplier or participating wholesaler may appeal such decision in accordance with the provisions of section 4-183 of the general statutes.

Sec. 6. (NEW) (*Effective July 1, 2022*) The commissioner may, in consultation with the Commissioner of Public Health, adopt regulations in accordance with the provisions of chapter 54 of the general statutes to implement the provisions of sections 1 to 5, inclusive, of this act.

Sec. 7. Section 38a-477ff of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to policies delivered, issued for delivery, renewed, amended or continued on or after January 1, 2022*):

(a) Each insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy in this state on or after January 1, 2022, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall, when calculating an insured's liability for a coinsurance, copayment, deductible or other out-of-pocket expense for a covered benefit, give credit for any discount provided or payment made by a third party for the amount of, or any portion of the amount of, the coinsurance, copayment, deductible or other out-of-pocket expense for the covered benefit.

(b) If, under federal law, application of subsection (a) of this section would result in health savings account ineligibility under Section 223 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to

time, this requirement shall apply for health savings account-qualified, high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of said internal revenue code, except for items or services that are preventive care pursuant to Section 223(c)(2)(C) of said internal revenue code, in which case the requirements of subsection (a) of this section shall apply regardless of whether the minimum deductible under Section 223 of said internal revenue code is satisfied.

Sec. 8. Section 38a-477gg of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to contracts entered into on or after January 1, 2022*):

(a) On and after January 1, 2022, each contract entered into between a health carrier, as defined in section 38a-591a, and a pharmacy benefits manager, as defined in section 38a-479aaa, for the administration of the pharmacy benefit portion of a health benefit plan in this state on behalf of plan sponsors shall require that the pharmacy benefits manager, when calculating an insured's or enrollee's liability for a coinsurance, copayment, deductible or other out-of-pocket expense for a covered prescription drug benefit, give credit for any discount provided or payment made by a third party for the amount of, or any portion of the amount of, the coinsurance, copayment, deductible or other out-of-pocket expense for the covered prescription drug benefit.

(b) If, under federal law, application of subsection (a) of this section would result in health savings account ineligibility under Section 223 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, this requirement shall apply for health savings account-qualified, high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of said internal revenue code, except for items or services that are preventive care pursuant to Section 223(c)(2)(C) of said internal revenue code, in which case the requirements of subsection (a) of this

section shall apply regardless of whether the minimum deductible under Section 223 of said internal revenue code is satisfied.

Sec. 9. Section 38a-478w of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to contracts delivered, issued for delivery, renewed, amended or continued on or after January 1, 2022*):

(a) For any contract delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, each managed care organization shall, when calculating an enrollee's liability for a coinsurance, copayment, deductible or other out-of-pocket expense for a covered benefit, give credit for any discount provided or payment made by a third party for the amount of, or any portion of the amount of, the coinsurance, copayment, deductible or other out-of-pocket expense for the covered benefit.

(b) If, under federal law, application of subsection (a) of this section would result in health savings account ineligibility under Section 223 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, this requirement shall apply for health savings account-qualified, high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of said internal revenue code, except for items or services that are preventive care pursuant to Section 223(c)(2)(C) of said internal revenue code, in which case the requirements of subsection (a) of this section shall apply regardless of whether the minimum deductible under Section 223 of said internal revenue code is satisfied.

Sec. 10. Section 38a-497 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or

continued in this state shall provide that coverage of a child, stepchild or other dependent child shall terminate not earlier than the policy anniversary date after the date on which the child, stepchild or other dependent child attains the age of twenty-six.

(b) Each individual health insurance policy described in subsection (a) of this section, and each individual health insurance policy providing coverage of the type specified in subdivision (16) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state, that includes or provides dental or vision coverage shall provide that dental or vision coverage of a child, stepchild or other dependent child shall terminate not earlier than the policy anniversary date after the date on which the child, stepchild or other dependent child attains the age of twenty-six.

(c) Each policy subject to this section shall cover a stepchild or other dependent child on the same basis as a biological child.

(d) Coverage for a child, stepchild or other dependent child under an insurance policy provided by the Comptroller for state employees or nonstate public employees pursuant to section 5-259 shall terminate not earlier than the end of the calendar year of the year in which the first of the following occurs: (1) The date such child, stepchild or other dependent child becomes covered under a group health plan through such dependent child's own employment; or (2) the date on which such dependent child attains the age of twenty-six.

(e) The provisions of subsection (d) of this section shall apply to insurance policies delivered, issued for delivery, amended, renewed or continued on or after July 1, 2022.

Sec. 11. Section 38a-512b of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section

38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child, stepchild or other dependent child shall terminate not earlier than the policy anniversary date after the date on which the child, stepchild or other dependent child attains the age of twenty-six.

(b) Each group health insurance policy described in subsection (a) of this section, and each group health insurance policy providing coverage of the type specified in subdivision (16) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state, that includes or provides dental or vision coverage shall provide that dental or vision coverage of a child, stepchild or other dependent child shall terminate not earlier than the policy anniversary date after the date on which the child, stepchild or other dependent child attains the age of twenty-six.

(c) Each policy subject to this section shall cover a stepchild or other dependent child on the same basis as a biological child.

(d) Coverage for a child, stepchild or other dependent child under an insurance policy provided by the Comptroller for state employees or nonstate public employees pursuant to section 5-259 shall terminate not earlier than the end of the calendar year of the year in which the first of the following occurs: (1) The date such child, stepchild or other dependent child becomes covered under a group health plan through such dependent child's own employment; or (2) the date on which such dependent child attains the age of twenty-six.

(e) The provisions of subsection (d) of this section shall apply to insurance policies delivered, issued for delivery, amended, renewed or continued on or after July 1, 2022.

Sec. 12. Section 38a-1084 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2023*):

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;

(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) Consult with the Commissioner of Social Services, Insurance Commissioner and Office of Health Strategy, established under section 19a-754a for the purposes set forth in section 19a-754c; **[**.**]** and

(27) (A) Notwithstanding the provisions of section 12-15, the exchange shall make written request from the Commissioner of Revenue Services, for return or return information, as such terms are defined in section 12-15, for use in conducting targeted outreach to uninsured residents of this state. If the Commissioner of Revenue Services deems such return or return information to be relevant to the exchange conducting targeted outreach to uninsured residents, said commissioner may disclose such information to the exchange. To effectuate the disclosure of such information, the Commissioner of Revenue Services and the exchange shall enter into a memorandum of understanding that sets forth the specific information to be disclosed and contains the terms and conditions under which said commissioner will disclose such information to the exchange. Any return or return information disclosed by the Commissioner of Revenue Services shall not be disclosed without permission to a third party and shall only be used by the exchange in the manner prescribed in the memorandum of understanding. Any person who violates this subparagraph shall be fined not more than five thousand dollars.

(B) To assist the exchange in conducting targeted outreach to uninsured residents of this state, the Commissioner of Revenue Services shall revise the tax return form prescribed under chapter 229 to include space on the tax return for residents to authorize the exchange to contact such residents regarding enrollment through the exchange. The Commissioner of Revenue Services and the exchange shall develop language to be included on the tax return form and shall include in the instructions accompanying the tax return a description of how the authorization provided will be relayed to the exchange.

Sec. 13. Section 4-5 of the 2022 supplement to the general statutes, as amended by section 6 of public act 17-237, section 279 of public act 17-2 of the June special session, section 20 of public act 18-182, section 283 of

public act 19-117 and section 254 of public act 21-2 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Services and Public Protection, Commissioner of Energy and Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Commissioner of Mental Health and Addiction Services, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Veterans Affairs, Commissioner of Housing, Commissioner of Rehabilitation Services, the Commissioner of Early Childhood, the executive director of the Office of Health Strategy, the executive director of the Office of Military Affairs, the executive director of the Technical Education and Career System and the Chief Workforce Officer. As used in sections 4-6 and 4-7, "department head" also means the Commissioner of Education.

Sec. 14. (*Effective from passage*) Not later than January 1, 2023, the Office of Health Strategy shall prepare and 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 include, but need not be limited to, an analysis of pharmacy benefit manager distribution of prescription drug practices regarding spread pricing arrangements, manufacturing rebates and transparency and accountability.

Sec. 15. (*Effective from passage*) Not later than January 1, 2023, the State Comptroller shall prepare and 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 include an analysis of state purchasing pools for prescription drugs and health care supplies, and shall describe: (1) Whether current pool purchasing arrangements with other states are resulting in cost savings in the state; and (2) whether other potential pool purchasing relationships may result in lower prescription drug and health care costs.

Sec. 16. Section 38a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2023*):

(a) Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(b) Coverage for such newly born child shall consist of coverage for injury and sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities within the limits of the policy.

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of such newly born child and payment of the required premium or fees shall be furnished to the insurer, hospital service corporation, medical service corporation or health care center not later than **[**sixty-one**]** ninety-one days after the date of birth in order to continue coverage beyond such **[**sixty-one-day**]** period, provided failure to furnish such notice or pay such premium or fees shall not prejudice any claim originating within such **[**sixty-one-day**]** period.

Sec. 17. Section 38a-516 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2023*):

(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(b) Coverage for such newly born child shall consist of coverage for injury and sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities within the limits of the policy.

(c) If payment of a specific premium fee is required to provide coverage for a child, the policy may require that notification of birth of such newly born child and payment of the required premium or fees shall be furnished to the insurer, hospital service corporation, medical service corporation or health care center not later than **[**sixty-one**]** ninety-one days after the date of birth in order to continue coverage beyond such **[**sixty-one-day**]** period, provided failure to furnish such notice or pay such premium shall not prejudice any claim originating within such **[**sixty-one-day**]** period.

Sec. 18. (*Effective from passage*) (a) There is established a task force to study common interest ownership communities. Such study shall include, but need not be limited to, an examination of the feasibility of requiring common interest ownership communities to maintain financial records that disclose reserve funds and liabilities, including any anticipated costs for maintenance, upgrades or compliance with law.

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

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

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

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

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

(5) One appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, whom shall be a realtor;

(6) One appointed by the House of Representatives chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to insurance;

(7) One appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance; and

(8) One appointed by the House of Representatives ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance.

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

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

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

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the task force.

(g) Not later than January 1, 2023, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2023, whichever is later."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2022*	New section
Sec. 2	*July 1, 2022*	New section
Sec. 3	*July 1, 2022*	New section
Sec. 4	*July 1, 2022*	New section
Sec. 5	*July 1, 2022*	New section
Sec. 6	*July 1, 2022*	New section
Sec. 7	*from passage and applicable to policies delivered, issued for delivery, renewed, amended or continued on or after January 1, 2022*	38a-477ff
Sec. 8	*from passage and applicable to contracts entered into on or after January 1, 2022*	38a-477gg
Sec. 9	*from passage and applicable to contracts delivered, issued for delivery, renewed, amended or continued on or after January 1, 2022*	38a-478w
Sec. 10	*July 1, 2022*	38a-497
Sec. 11	*July 1, 2022*	38a-512b
Sec. 12	*January 1, 2023*	38a-1084
Sec. 13	*July 1, 2022*	4-5
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	New section
Sec. 16	*January 1, 2023*	38a-490
Sec. 17	*January 1, 2023*	38a-516
Sec. 18	*from passage*	New section