PA 25-167—sHB 7192
Human Services Committee
Insurance and Real Estate Committee
Appropriations Committee

AN ACT IMPLEMENTING RECOMMENDATIONS OF THE BIPARTISAN DRUG TASK FORCE

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Allows the DCP commissioner, after a consultant's feasibility study, to seek federal approval to establish a program to import prescription drugs from Canada for distribution in the state; establishes several related requirements if the program is approved, such as on (1) drug safety, quality, and tracking and (2) Canadian suppliers' and participating wholesalers' documentation; provides for DCP enforcement and emergency actions and penalties (e.g., if the drugs are adulterated); and, if the drug importation program is not feasible, allows a DCP consultant to conduct a feasibility review of Canadian prescription drug price benchmarking and develop policy recommendations

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Creates a council to advise the DAS commissioner and drug purchasing agencies on prescription drug negotiations

§ 22 — GENERIC GLP-1 DRUGS FOR WEIGHT LOSS

Requires and authorizes the DSS commissioner to take certain steps to increase access to generic, lower cost forms of GLP-1 drugs for HUSKY Health members

SUMMARY: This act makes various changes related to prescription drugs, pharmacy benefits managers (PBMs), health carriers, and other related matters. A section-by-section analysis follows below.
EFFECTIVE DATE: Various, see below

§ 1 — PHARMACY BENEFITS MANAGER DUTY OF GOOD FAITH AND FAIR DEALING

Requires PBMs to use good faith and fair dealing under their contracts with health carriers or plan sponsors and in performing their duties with all parties; requires PBMs to notify health carriers and plan sponsors about any conflicts of interest with their duties under the act

The act requires PBMs to exercise good faith and fair dealing in performing their contractual duties to health carriers or other health benefit plan sponsors. It also specifies that a PBM has an obligation of good faith and fair dealing in performing its duties with all parties, including carriers and other plan sponsors with whom it interacts when performing its services.

Under the act, a PBM must notify the heath carrier or plan sponsor, in writing,

if any of the PBM's activities, policies, or practices directly or indirectly present a conflict of interest with these duties.

The act authorizes the insurance commissioner to adopt implementing regulations.

EFFECTIVE DATE: October 1, 2025

§ 2 — PBM DRUG PRICING FOR HEALTH PLANS

Requires a PBM to offer a health plan the option of being charged the same price for a prescription drug that the PBM pays a pharmacy for the drug

Starting January 1, 2026, the act requires a PBM to offer a health plan the option of being charged the same price for a prescription drug that the PBM pays a pharmacy for the drug.

As under existing law for prohibited provisions in these contracts:

1. any contract provision that violates the act is void and unenforceable, but a provision rendered invalid or unenforceable does not affect remaining provisions;
2. any general business practice that violates the act's provision is an unfair trade practice under the Connecticut Unfair Trade Practices Act (CUTPA, see *Background — Connecticut Unfair Trade Practices Act*); and
3. the insurance commissioner may enforce this provision and upon request, audit pharmacy services contracts for compliance.

EFFECTIVE DATE: January 1, 2026

Background — Connecticut Unfair Trade Practices Act

By law, CUTPA prohibits businesses from engaging in unfair and deceptive acts or practices. It allows the Department of Consumer Protection (DCP) commissioner, under specified procedures, to issue regulations defining an unfair trade practice, investigate complaints, issue cease and desist orders, order restitution in cases involving less than $10,000, impose civil penalties of up to $5,000, enter into consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and up to $25,000 for a restraining order violation.

§ 3 — HEALTH CARRIER REBATE ANNUAL REPORTING

Expands the contents of the insurance commissioner's annual report on health carrier rebates to include certain information on how rebates affected premiums and cost sharing

Existing law requires the insurance commissioner to annually report on health carrier rebate practices for the prior year and publish the report on the department's website. The act expands the report's required contents to include (1) the percentage of rebate dollars health carriers used to reduce premiums and (2) an evaluation of

rebate practices to reduce cost-sharing for health care plans delivered, issued, renewed, amended, or continued.

Under existing law, the report must include (1) an explanation of how carriers accounted for rebates when calculating premiums, (2) a statement disclosing whether and how carriers made rebates available to insureds at the point of purchase, (3) any other way carriers applied rebates, and (4) any other information the commissioner deems relevant.

EFFECTIVE DATE: October 1, 2025

§ 4 — HEALTH CARRIER PRICING AND PROFIT REPORTING REQUIREMENTS

Requires the insurance commissioner to require carriers to annually report on pricing for, and profit generated between, the carrier and any PBM or mail-order pharmacy, if the information is reasonably available and proprietary information is kept confidential

Under the act, the insurance commissioner must require health carriers to annually report on pricing in effect for the prior year, and profit generated between, the carrier and any PBM or mail-order pharmacy doing business with the carrier. This applies as long as the information is reasonably available to the carrier and the commissioner, under existing standards, keeps confidential any information that is marked as proprietary.

EFFECTIVE DATE: January 1, 2026

§ 5 — PRESCRIPTION DRUG SHORTAGES TASK FORCE

Creates a task force to study prescription drug shortage preparedness and mitigation

The act creates an ongoing task force to study emergency preparedness and mitigation strategies for prescription drug shortages. The task force must identify drugs at risk of shortage in this state and recommend ways to address that (see below).

EFFECTIVE DATE: Upon passage

Task Force Members, Administration, and Reporting Requirement

The task force includes eight members appointed by the legislative leaders, as shown in the following table. Appointees may be legislators.

Task Force Appointed Members

Appointing Authority	*Appointee Qualifications*
House speaker	• Expert in prescription drug supply chains • Expert in federal law on prescription drug shortages
Senate president pro tempore	• Representative of hospitals • Representative of providers who treat patients with rare diseases

Appointing Authority	*Appointee Qualifications*
House majority leader	• Representative of the Mohegan or Mashantucket Pequot tribes
Senate majority leader	• Representative of the Mohegan or Mashantucket Pequot tribes
House minority leader	• Representative of health insurance companies
Senate minority leader	• Representative of the Connecticut Health Insurance Exchange

The task force also includes the following seven officials or their designees: the DCP, economic and community development (DECD), health strategy, insurance, public health, and social services commissioners and UConn Health Center's chief executive officer.

Appointing authorities must make their initial appointments within 30 days after the act's passage (i.e. by August 7, 2025), and fill any vacancy.

The House speaker and Senate president pro tempore must select the task force chairpersons from among its members. The chairpersons may add any other members they deem necessary and must schedule and hold the first meeting within 60 days after the act's passage. The General Law Committee's administrative staff must serve in that capacity for the task force.

The act requires the task force, starting by January 1, 2026, to annually report its findings and recommendations to the General Law, Human Services, Insurance and Real Estate, and Public Health committees. The report must identify (1) those drugs the task force determines are at risk of shortage and (2) strategies to mitigate these shortages, including ways to increase in-state production of drugs that are at risk of shortage and critically necessary to provide health care in the state.

§ 6 — PRESCRIPTION DRUG PRODUCTION CAPACITY

Allows DECD to use bond proceeds to support prescription drug production capacity in the state

The act allows DECD to use bond proceeds from an existing bond authorization to support prescription drug production capacity in the state, as long as the commissioner may give preference to financial assistance applications that incorporate recommendations by the task force established above to prevent or mitigate prescription drug shortages (§ 5).

EFFECTIVE DATE: July 1, 2025

§ 7 — PHARMACISTS' COMPENSATION WORKING GROUP

Establishes a working group to study and make legislative recommendations on the compensation of pharmacists who administer vaccines, HIV-related tests, and influenza-related tests and prescribe FDA-approved contraceptive devices or products

By July 1, 2025, the act requires the chairpersons of the Insurance and Real Estate Committee, or their designees, to convene a working group to study and

make legislative recommendations on the compensation of licensed pharmacists who provide certain health care services, including vaccine administration, HIV-related tests, influenza-related tests, and prescribing federal Food and Drug Administration (FDA)-approved contraceptive devices or products.

The Insurance and Real Estate Committee's administrative staff must serve as the working group's staff.

EFFECTIVE: Upon passage

Membership and Appointments

The working group must consist of the Insurance and Real Estate Committee chairpersons and ranking members and the insurance and DCP commissioners, or their designees.

Additionally, by August 7, 2025, the Insurance and Real Estate Committee chairpersons must appoint the following members to the working group:

1. three licensed pharmacists, one each employed by an independent pharmacy (i.e. a privately owned pharmacy that has up to five stores located in Connecticut), chain pharmacy, and health system pharmacy;
2. three members, one each representing an (a) organization representing PBMs, (b) health insurance company doing business in Connecticut, and (c) pharmaceutical company doing business in Connecticut;
3. a faculty member of a school of pharmacy in Connecticut;
4. two members representing employers in Connecticut, including a small employer (less than 50 employees) and a large one (more than 100 employees); and
5. a representative of the Connecticut Health Insurance Exchange.

The Insurance and Real Estate Committee chairpersons may appoint any other members they deem necessary and must fill any vacancy.

Reporting

The working group must report its findings and legislative recommendations to the Insurance and Real Estate Committee by February 1, 2026. It terminates on that date or when it submits the report, whichever is later.

§ 8 — CREDIT FOR CERTAIN PRESCRIPTION DRUG COSTS UNDER HEALTH INSURANCE POLICIES AND HEALTH BENEFIT PLANS

Generally requires health carriers to credit insureds or enrollees for certain prescription drug costs when determining in-network liability for out-of-pocket expenses; establishes requirements for proof of payment an insured or enrollee must provide to receive credit for purchases from out-of-network providers; limits the total annual credit amount for out-of-network purchases and prohibits carryover to another policy period

The act requires health carriers to credit insureds or enrollees for certain prescription drug costs when determining in-network liability for out-of-pocket expenses paid directly to a pharmacy or health care provider.

It establishes proof of payment requirements an insured or enrollee must provide to the health carrier to receive credit for prescription drugs purchased from an out-of-network provider. For these purchases, the act also (1) limits the total amount credited toward any insured's or enrollee's annual out-of-pocket expense and (2) prohibits carrying over a credit to a new policy period.
EFFECTIVE: July 1, 2026

Calculation of In-Network Liability for Out-of-Pocket Expense

Under the act, when calculating an insured's or enrollee's in-network liability for his or her out-of-pocket expense (e.g., annual coinsurance, copayment, or deductible), each health carrier (see below) must give credit for any out-of-pocket expense the insured or enrollee pays directly to any state-licensed pharmacy or health care provider for any prescription drug, as long as:

1. no claim for the prescription drug was submitted to the carrier and
2. the out-of-pocket expense paid by the insured or enrollee is less than the average discounted rate for the drug paid to an in-network provider according to the terms of the policy or plan.

Under the act, this applies to insurers, health care centers (i.e. HMOs), hospital or medical service corporations, fraternal benefit societies, or other entities ("health carriers") that deliver, issue, renew, amend, or continue an individual or a group health insurance policy or health benefit plan in the state on or after January 1, 2026, providing coverage for (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

Prescription Drug From Out-of-Network Health Care Provider

Under the act, if an insured or enrollee purchases a prescription drug from any out-of-network health care provider for a lower amount than the average amount paid by the insured's or enrollee's health carrier to any in-network provider for the same drug, the health carrier must give credit for the purchase when calculating the insured's or enrollee's liability for in-network annual out-of-pocket expenses. This applies if the insured or enrollee gives the carrier proof of payment following the requirements below.

The act specifies that this provision must not be construed to restrict any health insurance policy or health benefit plan from requiring a prior authorization or precertification otherwise provided for in the insured's or enrollee's policy or plan.

Proof of Payment. The act requires health carriers to (1) develop a proof of payment form and publish it on their website for insureds and enrollees to submit proof of payment for any out-of-network prescription drug purchase as described above and (2) annually give them written notice of, and instructions for downloading or electronically submitting, the form.

Upon receiving a proof of payment form from an insured or enrollee, a carrier must give credit for any out-of-pocket payments that the insured or enrollee paid to any out-of-network pharmacy or health care provider under the provision above, if

the:

1. prescription drug the insured or enrollee purchased is included under his or her policy or plan and
2. insured or enrollee purchased the drug for a lower price than the average amount paid by the carrier to an in-network provider for the same drug.

Out-of-Pocket Maximum and Prohibited Carryover. Under the act, the total amount credited toward any insured's or enrollee's annual out-of-pocket expense for prescription drugs purchased from an out-of-network provider must not (1) exceed the total amount that the insured or enrollee must pay out-of-pocket under the terms of the policy or plan during a policy period and (2) carry over to a new policy period.

§§ 9-18 — CANADIAN PRESCRIPTION DRUG IMPORTATION PROGRAM

Allows the DCP commissioner, after a consultant's feasibility study, to seek federal approval to establish a program to import prescription drugs from Canada for distribution in the state; establishes several related requirements if the program is approved, such as on (1) drug safety, quality, and tracking and (2) Canadian suppliers' and participating wholesalers' documentation; provides for DCP enforcement and emergency actions and penalties (e.g., if the drugs are adulterated); and, if the drug importation program is not feasible, allows a DCP consultant to conduct a feasibility review of Canadian prescription drug price benchmarking and develop policy recommendations

The act allows the DCP commissioner, on behalf of the state and following a consultant's feasibility study, to seek federal approval to establish a Canadian prescription drug importation program, to import drugs that have the highest potential for cost savings in the state.

If the drug importation program is not likely to lead to significant cost savings, the act allows the DCP-contracted consultant to conduct a feasibility review of Canadian prescription drug price benchmarking and develop policy recommendations.

EFFECTIVE DATE: October 1, 2027, except the provisions that define the applicable terms and require the feasibility study are effective July 1, 2025.

Feasibility Study and Report; Consultant Responsibilities (§ 10)

The act requires the DCP commissioner to:

1. hire, within available resources, a consultant to study the feasibility of establishing a Canadian prescription drug importation program to reduce prescription drug costs in the state and
2. report the findings to the Appropriations, General Law, and Human Services committees and the Office of Policy and Management (OPM) by October 1, 2027.

Within six months after being contracted, the consultant must recommend to the DCP commissioner whether it is more likely than not that a prescription drug importation program is feasible and will result in cost savings to the state.

If the consultant determines that it is not likely to result in significant savings, he or she must give a written justification for the determination and may (1) start a

feasibility review of Canadian prescription drug price benchmarking and (2) develop policy recommendations for implementing an upper payment limit for prescription drugs in the state based on the Canadian price benchmarking.

Food and Drug Administration Approval (§ 11)

Request for FDA Approval. If the DCP commissioner, after the consultant's study and in consultation with the OPM secretary, determines that the Canadian drug importation program is feasible, the act authorizes the commissioner to request program approval from the FDA under federal law.

The request to the FDA must at least do the following:

1. describe (a) the state's plans for operating the program and (b) any opportunities to coordinate with other states,
2. demonstrate that any prescription drug imported and distributed in this state under the program would (a) meet all applicable federal and state standards for safety and effectiveness and (b) comply with all federal tracing procedures, and
3. state the estimated program implementation costs.

The act authorizes the DCP commissioner to spend resources before FDA approval to ensure efficient implementation, but it prohibits the commissioner from actually operating the program without FDA approval.

FDA-Approval Received. If the FDA approves the request, the DCP commissioner must submit a notice disclosing it to the OPM secretary; social services and health strategy commissioners; and Appropriations, General Law, Human Services, and Public Health committees.

Prescription Drug Importation, Distribution, and Standards (§§ 9, 12 & 13)

Importation and Distribution. If a Canadian prescription drug importation program is established under the act, participating wholesalers may, subject to the act's provisions and under the program, import and distribute drugs from a participating Canadian supplier to pharmacies, institutional pharmacies, and qualifying laboratories in the state.

Under the act, an "institutional pharmacy" is the area within a care-giving, correctional, or juvenile training institution where drugs are stored and dispensed under the direct charge of a pharmacist.

Drug. For the Canadian prescription drug importation program, a "drug" is an article that is:

1. recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, official National Formulary, or any of their supplements;
2. intended to diagnose, cure, mitigate, treat, or prevent disease in humans;
3. not food and intended to affect the structure or any function of the human body; and
4. not a device and intended for use as a component of any article specified in those listed above.

Participating Wholesaler. A "participating wholesaler" in the program is designated by DCP to distribute prescription drugs in the manufacturer's original container, obtained from a participating Canadian supplier.

Participating Canadian Supplier. A "Canadian supplier" is a manufacturer or wholesale drug distributor licensed or permitted under Canadian law to manufacture or distribute prescription drugs. A "participating Canadian supplier" is such a supplier that is exporting prescription drugs, in the manufacturer's original container, to a participating wholesaler for distribution in the state under the program.

Drug Standards. Under the program, participating wholesalers may import and distribute prescription drugs in this state from a participating Canadian supplier if doing so would not violate federal patent laws and the drug meets the FDA's drug safety, effectiveness, misbranding, and adulteration standards.

A drug cannot be imported under the program if it is:

1. considered a controlled substance under federal law;
2. a biological product (e.g., a virus, therapeutic serum, vaccine, blood, or blood component applied to prevent, treat, or cure a human disease or condition);
3. inhaled during surgery, infused, or intravenously injected; or
4. a parenteral drug that the federal Health and Human Services (HHS) secretary determines would pose a threat to the public health if imported.

Track-and-Trace-Related Requirements (§§ 9 & 14)

Under the program, the DCP commissioner must require participating Canadian suppliers and participating wholesalers to (1) comply with all applicable track-and-trace requirements and (2) make all track-and-trace records available within 48 hours after the commissioner requests them.

"Track-and-trace" is the product tracing process in the federal Drug Quality and Security Act for the components of the pharmaceutical distribution supply chain.

The DCP commissioner must prohibit the distribution, dispensing, or sale outside the state of any prescription drug imported under the program.

Safety and Quality Requirements (§§ 9 & 15(a))

Under the act, a participating wholesaler must ensure the safety and quality of all drugs imported and distributed in the state under the program.

Drug Requirements. The drugs must (1) be approved for marketing in the United States; (2) not be adulterated or misbranded; and (3) meet all labeling requirements (e.g., content, prominence of information, and designation of established names) under federal law.

Laboratory Testing. Under the act, "laboratory testing" is a quantitative and qualitative analysis of a drug consistent with the applicable provisions of the official United States Pharmacopoeia.

The act requires a participating wholesaler to engage a qualifying laboratory (i.e. one in the United States approved by the FDA for the federal Food, Drug, and

Cosmetic Act's provisions on Canadian drug importation) to test for authenticity and degradation a (1) statistically valid sample size for each batch of each drug in the initial shipment and (2) statistically valid sample of the shipment.

The laboratory's testing must be consistent with the federal Food, Drug and Cosmetic Act.

Wholesaler Records Maintenance and Retention Requirements (§ 15(a) to (c))

Under the program, a participating wholesaler must maintain:

1. qualifying laboratory records, including complete data derived from all tests needed to ensure that each drug imported under the program complies with the act's safety and quality requirements, and
2. documentation showing that the required testing was done at a qualifying laboratory consistent with the federal Food, Drug and Cosmetic Act and all other applicable federal and state laws and regulations on qualifying laboratory qualifications.

After a qualifying laboratory submits information and documentation to the participating wholesaler, the wholesaler must keep them for at least three years from the submission date.

A participating wholesaler must also maintain the following information for each drug the wholesaler imports and distributes in the state under the program, and submit it to the DCP commissioner upon his request:

1. the name and quantity of the drug's active ingredient and a description of the drug's dosage form,
2. the date the wholesaler received the drug and the price the wholesaler paid,
3. the quantity the wholesaler received and the drug's point of origin and destination,
4. a report on any drug that fails qualifying laboratory testing, and
5. any additional information and documentation that the commissioner deems necessary to protect public health.

Participating Supplier Documentation Requirements (§ 15(d))

The DCP commissioner must require each participating Canadian supplier to maintain the following information and documentation for each drug the supplier exports into the state under the program:

1. the drug's original source, including the manufacturer's name and manufacture date and location;
2. the shipping date and quantity;
3. the quantity of each lot of the drug originally received and the source of the lot;
4. the lot or control number and batch number the manufacturer assigned to the drug; and
5. any additional information and documentation that the DCP commissioner deems necessary to ensure public health protection.

The supplier must submit the above information and documentation to the

commissioner, upon the commissioner's request.

Authorized Emergency Actions for Public Health or Welfare (§ 16)

The act authorizes the DCP commissioner to issue cease and desist, recall, embargo, or destruction orders to program participants when warranted and subject to administrative proceedings and penalties.

Cease and Desist Order. If the DCP commissioner determines that public health, safety, or welfare requires emergency action, the commissioner may order a participating Canadian supplier, participating wholesaler, re-labeler, re-packer, and qualifying laboratory to cease and desist from actions specified in the order pending administrative proceedings. The cease and desist order must be in writing and signed by the commissioner and is effective upon delivery to the respondent.

Administrative Proceeding and Civil Penalty. After a cease and desist order is issued, an administrative proceeding under the Uniform Administrative Procedure Act must begin promptly. After a hearing, the commissioner may impose a civil penalty up to $5,000.

Recall, Embargo, or Destruction. The commissioner may require the recall, embargo, or destruction of any drug that was imported and distributed under the program that has been identified as adulterated or misbranded. The action must be done according to DCP's process for food, drug, and cosmetic seizures and embargoes in existing law, which includes a hearing and possible civil penalty.

Generally, a drug is deemed adulterated under several circumstances, such as if it consists of any filthy, putrid, or decomposed substance, or has been produced, prepared, packed, or held under insanitary conditions so that it may have been contaminated with filth or made injurious to health.

Written Notice to Impacted Businesses. If a cease and desist, recall, embargo, or destruction order is issued, the person adversely impacted by the order must notify all other businesses participating in the program about the order. The notice must be in writing.

DCP Regulations and Report to the General Assembly (§§ 17 & 18)

If a Canadian prescription drug importation program is established, the act allows the DCP commissioner to adopt implementing regulations.

Starting by 180 days after the first importation, the commissioner must biannually submit a report to the Appropriations, General Law, Human Services, and Public Health committees describing the program operation, any violations that resulted in action being taken by the commissioner, and the status of any violation investigations.

§§ 19 & 20 — STATE DRUG PURCHASING AGENCY PRICE NEGOTIATIONS

Generally requires DAS to negotiate bulk prices for prescription drugs on behalf of the state's drug purchasing agencies in order to buy them at lower cost; allows drug purchasing agencies, when negotiating drug prices with manufacturers, to incorporate the maximum fair price

negotiated by CMS; allows drug purchasing agencies to enter compacts with other states for these purposes

The act generally requires the Department of Administrative Services (DAS) to negotiate bulk prices for prescription drugs on behalf of the drug purchasing agencies, which under the act are the judicial branch and the departments of Children and Families, Developmental Services, Mental Health and Addiction Services, and Public Health. DAS must do so with the goal to buy these drugs at lower prices than if the agencies each purchased them. The DAS commissioner or his designee must report by February 1, 2026, to the Appropriations, General Law, Human Services, and Public Health committees on any savings achieved through bulk purchasing of prescription drugs.

Under the act, a drug purchasing agency may negotiate its own drug prices if operational conditions require or it demonstrates, in writing, to the DAS commissioner that it is able to purchase the drugs at a cheaper price than the state's bulk pricing agreements.

The act allows the drug purchasing agencies, when negotiating with drug manufacturers to supply drugs for state-subsidized health care programs, to incorporate as a guiding price the maximum fair price negotiated by the federal Centers for Medicare and Medicaid Services (CMS) for certain drugs under the federal Inflation Reduction Act (see *Background — Maximum Fair Price*). It requires the agencies to consider the recommendations of the Advisory Council on Pharmaceutical Procurement (see § 21) in these negotiations.

The act also allows the drug purchasing agencies, either when negotiating bulk prices or referencing CMS's maximum fair price, to enter into a compact with officials in other states to increase the state's purchasing power in negotiations.

EFFECTIVE DATE: July 1, 2025

Background — Maximum Fair Price

Federal law requires the CMS secretary to negotiate with manufacturers on the maximum fair price of certain drugs covered under Medicare. The secretary must do so for 10 drugs starting in 2026, 15 more for each of the next two years, and 20 additional per year starting in 2028. For the first two years, this only applies to certain drugs under Medicare Part D; in the third year, it extends to Medicare Part B (42 U.S.C. § 1320f et seq.).

§ 21 — ADVISORY COUNCIL ON PHARMACEUTICAL PROCUREMENT

Creates a council to advise the DAS commissioner and drug purchasing agencies on prescription drug negotiations

The act establishes an Advisory Council on Pharmaceutical Procurement to advise the DAS commissioner and drug purchasing agencies on drug negotiations (see §§ 19 & 20).

EFFECTIVE DATE: October 1, 2025

Council Members, Administration, and Reporting Requirement

Under the act, the governor must (1) appoint the council's five members, who must have expertise in health policy, health care economics, or clinical medicine, and (2) designate one member to serve as the council's chairperson. All initial appointments must be made by October 31, 2025, and the governor must fill any vacancy.

The council's members may not (1) have a direct ownership or investment interest in a pharmaceutical company; (2) be employed by or participate in the management of such a company; or (3) receive or have the right to receive, directly or indirectly, remuneration under a compensation arrangement with such a company.

The council's chairperson must schedule and hold the first meeting by November 30, 2025.

The act requires the council, starting by January 1, 2026, to annually report its findings and recommendations to the DAS commissioner and the General Law, Human Services, and Public Health committees.

§ 22 — GENERIC GLP-1 DRUGS FOR WEIGHT LOSS

Requires and authorizes the DSS commissioner to take certain steps to increase access to generic, lower cost forms of GLP-1 drugs for HUSKY Health members

The act requires the Department of Social Services (DSS) commissioner, by August 7, 2025, to petition the federal HHS secretary to authorize generic, lower cost forms of glucagon-like peptide (GLP-1) prescription drugs (e.g., Ozempic) that are FDA approved to treat obesity or diabetes. (As of the act's passage, there were two generic versions of GLP-1 drugs approved to treat diabetes, but none specifically approved to treat obesity.)

Under the act, if HHS approves the petition, the DSS commissioner may contract with a manufacturer to supply the state with a generic form of these drugs for HUSKY Health members. The commissioner may enter into a consortium with other states in such a contract.

EFFECTIVE DATE: Upon passage