# State PBM Reform Inventory

*Updated October 2026*

# Connecticut

| Issue | Summary | Citation |
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| Licensing/Registration | PBMs must obtain a certificate of registration from the Insurance Commissioner before operating in the state. PBMs must annually apply for renewal.<br><br>A PBM operating as a line of business or affiliate of a health insurer, hospital service corporation, medical service corporation, or fraternal benefit society licensed in the state is exempt from this requirement. However, the parent entity must notify the Insurance Commissioner annually that it is affiliated with or operates a PBM. | Conn. Gen. Stat. § 38a-479bbb |
| Reporting Requirements | PBMs must file a report annually to the Department of Insurance, no later than February 1, containing the following information about pharmacy benefits managed by the PBM in the previous year's calendar:<br>• Aggregate dollar amount of all rebates collected from pharmaceutical manufacturers for products that were covered by contracted health plans and are attributable to patient utilization.<br>• Aggregate dollar amount of all rebates that were not received by health carriers that contracted with the PBM<br><br>The Insurance Commissioner must establish a standardized form for reporting information. The Commissioner shall submit a report by March 1 of each year to the General Assembly aggregating the information submitted by all PBMs. The Commissioner may impose a penalty of up to $7,500 for each violation.<br><br>Each health carrier must submit the following information to the Insurance Commissioner when the carrier submits a rate filing for a health plan:<br>• For covered outpatient drugs, the 25 most frequently prescribed drugs, the 25 drugs the health plan covered at | Conn. Gen. Stat. § 38a-479ppp;<br><br>Conn. Gen. Stat. § 38a-479qqq |

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| | the greatest cost, and the 25 drugs that experienced the greatest year-over-year increase in cost.<br>• The portion of the premium for such health plan that is attributable to covered outpatient drugs, stratified by brand name drugs, generic drugs, or specialty drugs.<br>• The year-over-year increase, calculated on a per-member, per-month basis and expressed as a percentage, in the annual total cost of brand-name drugs, generic drugs, and specialty drugs covered by the plan.<br>• A comparison, calculated on a per-member, per-month basis, of the year-over-year increase in the cost of covered outpatient drugs to the increase in the costs of other contributors to the premium costs of the health plan.<br>• The name of each specialty drug covered during the calendar year.<br>• The names of the 25 most frequently prescribed outpatient prescription drugs for which the carrier received manufacturer rebates. | |
| PBM Income | N/A | |
| Pharmacy Contracting | N/A | |
| Patient Cost-Sharing | **Copay Adjustment Programs:**<br>When calculating an enrollee's liability for a coinsurance, copay, deductible, or other out-of-pocket expense for a covered benefit, an MCO shall give credit for any discount provided or payment made by a third party.<br><br>**Maximum Cost-Sharing Levels:**<br>No health carrier or PBM shall require an individual to make a payment at the point of sale for a covered drug that is greater than the lesser of 1) the applicable copayment, 2) the allowable claim amount (i.e. the amount the carrier or PBM has agreed to pay the pharmacy), or 3) the amount an individual would pay without using a health benefit plan or any other source of discounts.<br><br>**Copay Cap:**<br>Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the treatment of all types of diabetes. No policy shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses on an insured that exceed: | Conn. Gen. Stat. § 38a-478w;<br><br>Conn. Gen. Stat § 38a-477cc;<br><br>Conn. Gen. Stat. § 38a-492d |

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| | • $25 for each 30-day supply of a medically necessary covered insulin drug,<br>• $25 for each 30-day supply of a medically necessary covered noninsulin drug if such noninsulin drug is a glucagon drug.<br>• $100 for a 30-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan. | |