PA 21-96—HB 6622
Insurance and Real Estate Committee

AN ACT CONCERNING PRESCRIPTION DRUG FORMULARIES AND LISTS OF COVERED DRUGS

SUMMARY: This act prohibits certain health carriers (e.g., insurers and HMOs) from removing from a formulary (i.e., a list of covered prescription drugs) or moving to a higher cost-sharing tier, any covered prescription drug during the plan year, except as specifically allowed (see below). This applies (1) to health carriers that offer a health benefit plan that covers prescription drugs and uses a formulary and (2) regardless of any other general statute provision (see BACKGROUND).

Additionally, the act requires the Office of Health Strategy (OHS), at least annually, to conduct a study to determine the financial impact of the act's requirements on the cost of commercial health plans in the state, including those offered and sold on the exchange (i.e., Access Health CT). Beginning by January 31, 2023, OHS must annually report the study results for the preceding year to the insurance commissioner and the Insurance and Real Estate Committee.
EFFECTIVE DATE: January 1, 2022

PERMITTED FORMULARY CHANGES

Under the act, a health carrier may remove a prescription drug from a formulary with at least 90 days' advance notice to a covered person and his or her treating physician if the U.S. Food and Drug Administration (FDA):

1. issues an announcement, guidance, or similar statement questioning the drug's clinical safety, unless the treating physician states in writing that the drug remains medically necessary for the covered person, or
2. approves the drug for over-the-counter use.

The act allows a carrier to move a drug to a higher cost-sharing tier if it is available in-network for $40 or less per month in any tier. It also allows a carrier to move a brand name drug to a higher cost-sharing tier if it adds an FDA-approved generic alternative to the formulary at a lower cost-sharing tier than the brand name drug.

Lastly, the act specifies that it does not prevent or prohibit a carrier from adding a prescription drug to a formulary at any time.

APPLICABILITY OF THE ACT'S PROVISIONS

The act generally applies to each insurer, HMO, hospital or medical service corporation, fraternal benefit society, or other entity that delivers, issues, renews, amends, or continues individual or group health insurance policies in Connecticut

on or after January 1, 2022, that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services. However, it does not apply to a grandfathered health plan, which is a plan that existed on March 23, 2010, and has not made significant coverage changes since.

Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Related Law

The law prohibits health carriers that cover outpatient prescription drugs from denying coverage for any drug removed from a formulary if (1) an insured person was using the drug to treat a chronic illness and had been covered for it before the removal and (2) his or her attending physician states in writing, after the removal, that the drug is medically necessary and why it is more beneficial than other formulary drugs (CGS §§ 38a-492f & 38a-518f).