



House Bill No. 6622

Public Act No. 21-96

**AN ACT CONCERNING PRESCRIPTION DRUG FORMULARIES
AND LISTS OF COVERED DRUGS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

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 Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

Terms used in this title and section 2 of this act, unless it appears from the context to the contrary, shall have a scope and meaning as set forth in this section.

(1) "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

(2) "Alien insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of any jurisdiction or country without the United States.

(3) "Annuities" means all agreements to make periodical payments where the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life or is for a specified term of years. This definition does not apply to payments made under a policy of life

House Bill No. 6622

insurance.

(4) "Commissioner" means the Insurance Commissioner.

(5) "Control", "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with the person.

(6) "Domestic insurer" means any insurer that has been chartered by, incorporated, organized or constituted within or under the laws of this state.

(7) "Domestic surplus lines insurer" means any domestic insurer that has been authorized by the commissioner to write surplus lines insurance.

(8) "Foreign country" means any jurisdiction not in any state, district or territory of the United States.

(9) "Foreign insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of another state or a territory of the United States.

(10) "Insolvency" or "insolvent" means, for any insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (A) Capital and surplus required by law for its organization and continued operation; or (B) the total par or stated value of its authorized and issued capital stock. For purposes of this subdivision "liabilities" shall include but not be limited to reserves required by statute or by regulations adopted by the commissioner in accordance with the provisions of chapter 54 or specific requirements imposed by the commissioner upon a subject

House Bill No. 6622

company at the time of admission or subsequent thereto.

(11) "Insurance" means any agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency or to provide indemnity for loss in respect to a specified subject by specified perils in return for a consideration. In any contract of insurance, an insured shall have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the insurer and such assumption shall be part of a general scheme to distribute losses among a large group of persons bearing similar risks in return for a ratable contribution or other consideration.

(12) "Insurer" or "insurance company" includes any person or combination of persons doing any kind or form of insurance business other than a fraternal benefit society, and shall include a receiver of any insurer when the context reasonably permits.

(13) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy. The term includes policyholders, subscribers, members and beneficiaries. This definition applies only to the provisions of this title and does not define the meaning of this word as used in insurance policies or certificates.

(14) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life. The business of life insurance includes granting endowment benefits, granting additional benefits in the event of death by accident or accidental means, granting additional benefits in the event of the total and permanent disability of the insured, and providing optional methods of settlement of proceeds. Life insurance includes burial contracts to the extent provided by section 38a-464.

(15) "Mutual insurer" means any insurer without capital stock, the

House Bill No. 6622

managing directors or officers of which are elected by its members.

(16) "Person" means an individual, a corporation, a partnership, a limited liability company, an association, a joint stock company, a business trust, an unincorporated organization or other legal entity.

(17) "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

(18) "State" means any state, district, or territory of the United States.

(19) "Subsidiary" of a specified person means an affiliate controlled by the person directly, or indirectly through one or more intermediaries.

(20) "Unauthorized insurer" or "nonadmitted insurer" means an insurer that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state or an insurer transacting business not authorized by a valid certificate.

(21) "United States" means the United States of America, its territories and possessions, the Commonwealth of Puerto Rico and the District of Columbia.

Sec. 2. (NEW) (*Effective January 1, 2022*) (a) For the purposes of this section:

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

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

(3) "Health benefit plan" has the same meaning as provided in section 38a-1080 of the general statutes, except that such term shall not include

House Bill No. 6622

a grandfathered health plan as such term is used in the Affordable Care Act;

(4) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes;

(5) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a of the general statutes; and

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

(b) Notwithstanding any provision of the general statutes and except as provided in subsection (c) of this section, no health carrier offering a health benefit plan in this state on or after January 1, 2022, that includes a pharmacy benefit and uses a drug formulary or list of covered drugs may:

(1) Remove a prescription drug from the drug formulary or list of covered drugs during a plan year; or

(2) Move a prescription drug from a cost-sharing tier that imposes a lesser coinsurance, copayment or deductible for the prescription drug to a cost-sharing tier that imposes a greater coinsurance, copayment or deductible for the prescription drug during a plan year, unless the prescription drug is subject to an in-network coinsurance, copayment or deductible that is not greater than forty dollars per prescription per month in any tier.

(c) A health carrier offering a health benefit plan in this state on or after January 1, 2022, that includes a pharmacy benefit and uses a drug formulary or list of covered drugs may:

(1) Remove a prescription drug from the drug formulary or list of covered drugs, upon at least ninety days' advance notice to a covered

House Bill No. 6622

person and the covered person's treating physician, if:

(A) The federal Food and Drug Administration issues an announcement, guidance, notice, warning or statement concerning the prescription drug that calls into question the clinical safety of the prescription drug, unless the covered person's treating physician states, in writing, that the prescription drug remains medically necessary despite such announcement, guidance, notice, warning or statement; or

(B) The prescription drug is approved by the federal Food and Drug Administration for use without a prescription; and

(2) Move a brand-name prescription drug from a cost-sharing tier that imposes a lesser coinsurance, copayment or deductible for the brand-name prescription drug to a cost-sharing tier that imposes a greater coinsurance, copayment or deductible for the brand-name prescription drug if the health carrier adds to the drug formulary or list of covered drugs a generic prescription drug that is:

(A) Approved by the federal Food and Drug Administration for use as an alternative to such brand-name prescription drug; and

(B) In a cost-sharing tier that imposes a coinsurance, copayment or deductible for the generic prescription drug that is lesser than the coinsurance, copayment or deductible that is imposed for such brand-name prescription drug.

(d) Nothing in this section shall prevent or prohibit a health carrier from adding a prescription drug to a formulary or list of covered drugs at any time.

(e) (1) The Office of Health Strategy shall, at least annually, conduct a study to determine the impact that the requirements established in subsections (a) to (d), inclusive, of this section have on the cost of health benefit plans offered, delivered, issued for delivery, renewed, amended

House Bill No. 6622

or continued in this state and qualified health plans offered and sold through the exchange.

(2) Not later than January 31, 2023, and annually thereafter, the Office of Health Strategy shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the commissioner and the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such report shall disclose the results of the study conducted pursuant to subdivision (1) of this subsection for the preceding year.