



General Assembly

**Amendment**

January Session, 2015

LCO No. 8934



Offered by:

REP. ORANGE, 48<sup>th</sup> Dist.

REP. BACKER, 121<sup>st</sup> Dist.

REP. ROSE, 118<sup>th</sup> Dist.

To: Subst. House Bill No. 6867

File No. 375

Cal. No. 231

**"AN ACT CONCERNING HEALTH CARE PROVIDER NETWORK ADEQUACY."**

1 After the last section, add the following and renumber sections and  
2 internal references accordingly:

3 "Sec. 501. Section 38a-510 of the general statutes is repealed and the  
4 following is substituted in lieu thereof (*Effective January 1, 2016*):

5 (a) No insurance company, hospital service corporation, medical  
6 service corporation, health care center or other entity delivering,  
7 issuing for delivery, renewing, amending or continuing an individual  
8 health insurance policy or contract that provides coverage for  
9 prescription drugs may:

10 (1) Require any person covered under such policy or contract to  
11 obtain prescription drugs from a mail order pharmacy as a condition  
12 of obtaining benefits for such drugs; [or]

13 (2) Impose a coinsurance, copayment, deductible or other out-of-  
14 pocket expense that exceeds (A) two hundred dollars per thirty-day  
15 supply for a covered drug under an individual health insurance policy  
16 or contract that has an actuarial value, as defined in 45 CFR 156.20, as  
17 amended from time to time, of sixty per cent, as calculated pursuant to  
18 45 CFR 156.135, as amended from time to time, plus or minus two per  
19 cent, or (B) one hundred dollars per thirty-day supply for a covered  
20 prescription drug under any other individual health insurance policy  
21 or contract;

22 (3) Place all prescription drugs in a given class in the highest cost-  
23 sharing tier of a tiered prescription drug formulary; or

24 ~~[(2)]~~ (4) (A) Require, if such insurance company, hospital service  
25 corporation, medical service corporation, health care center or other  
26 entity uses step therapy for such drugs, the use of step therapy for any  
27 prescribed drug for longer than sixty days. At the expiration of such  
28 time period, an insured's treating health care provider may deem such  
29 step therapy drug regimen clinically ineffective for the insured, at  
30 which time the insurance company, hospital service corporation,  
31 medical service corporation, health care center or other entity shall  
32 authorize dispensation of and coverage for the drug prescribed by the  
33 insured's treating health care provider, provided such drug is a  
34 covered drug under such policy or contract. If such provider does not  
35 deem such step therapy drug regimen clinically ineffective or has not  
36 requested an override pursuant to [subdivision (1) of subsection (b) of  
37 this section] subparagraph (B) of this subdivision, such drug regimen  
38 may be continued. For purposes of this section, "step therapy" means a  
39 protocol or program that establishes the specific sequence in which  
40 prescription drugs for a specified medical condition are to be  
41 prescribed.

42 ~~[(b) (1)]~~ (B) Notwithstanding the sixty-day period set forth in  
43 [subdivision (2) of subsection (a) of this section] subparagraph (A) of  
44 this subdivision, each insurance company, hospital service  
45 corporation, medical service corporation, health care center or other

46 entity that uses step therapy for such prescription drugs shall establish  
47 and disclose to its health care providers a process by which an  
48 insured's treating health care provider may request at any time an  
49 override of the use of any step therapy drug regimen. Any such  
50 override process shall be convenient to use by health care providers  
51 and an override request shall be expeditiously granted when an  
52 insured's treating health care provider demonstrates that the drug  
53 regimen required under step therapy [(A)] (i) has been ineffective in  
54 the past for treatment of the insured's medical condition, [(B)] (ii) is  
55 expected to be ineffective based on the known relevant physical or  
56 mental characteristics of the insured and the known characteristics of  
57 the drug regimen, [(C)] (iii) will cause or will likely cause an adverse  
58 reaction by or physical harm to the insured, or [(D)] (iv) is not in the  
59 best interest of the insured, based on medical necessity.

60 [(2)] (C) Upon the granting of an override request, the insurance  
61 company, hospital service corporation, medical service corporation,  
62 health care center or other entity shall authorize dispensation of and  
63 coverage for the drug prescribed by the insured's treating health care  
64 provider, provided such drug is a covered drug under such policy or  
65 contract.

66 [(c)] (D) Nothing in this [section] subdivision shall [(1)] (i) preclude  
67 an insured or an insured's treating health care provider from  
68 requesting a review under sections 38a-591c to 38a-591g, inclusive, or  
69 [(2)] (ii) affect the provisions of section 38a-492i.

70 (b) The provisions of subdivision (2) of subsection (a) of this section  
71 shall not apply to (1) a high deductible health plan, as that term is used  
72 in subsection (f) of section 38a-493, until after the minimum annual  
73 deductible for such plan has been met, or (2) a catastrophic plan, as  
74 defined in 45 CFR 156.155, as amended from time to time.

75 Sec. 502. Section 38a-544 of the general statutes is repealed and the  
76 following is substituted in lieu thereof (*Effective January 1, 2016*):

77 (a) No insurance company, hospital service corporation, medical  
78 service corporation, health care center or other entity delivering,  
79 issuing for delivery, renewing, amending or continuing a group health  
80 insurance policy or contract that provides coverage for prescription  
81 drugs may:

82 (1) Require any person covered under such policy or contract to  
83 obtain prescription drugs from a mail order pharmacy as a condition  
84 of obtaining benefits for such drugs; [or]

85 (2) Impose a coinsurance, copayment, deductible or other out-of-  
86 pocket expense that exceeds (A) two hundred dollars per thirty-day  
87 supply for a covered drug under a group health insurance policy or  
88 contract that has an actuarial value, as defined in 45 CFR 156.20, as  
89 amended from time to time, of sixty per cent, as calculated pursuant to  
90 45 CFR 156.135, as amended from time to time, plus or minus two per  
91 cent, or (B) one hundred dollars per thirty-day supply for a covered  
92 prescription drug under any other group health insurance policy or  
93 contract;

94 (3) Place all prescription drugs in a given class in the highest cost-  
95 sharing tier of a tiered prescription drug formulary; or

96 [(2)] (4) (A) Require, if such insurance company, hospital service  
97 corporation, medical service corporation, health care center or other  
98 entity uses step therapy for such drugs, the use of step therapy for any  
99 prescribed drug for longer than sixty days. At the expiration of such  
100 time period, an insured's treating health care provider may deem such  
101 step therapy drug regimen clinically ineffective for the insured, at  
102 which time the insurance company, hospital service corporation,  
103 medical service corporation, health care center or other entity shall  
104 authorize dispensation of and coverage for the drug prescribed by the  
105 insured's treating health care provider, provided such drug is a  
106 covered drug under such policy or contract. If such provider does not  
107 deem such step therapy drug regimen clinically ineffective or has not  
108 requested an override pursuant to [subdivision (1) of subsection (b) of

109 this section] subparagraph (B) of this subdivision, such drug regimen  
110 may be continued. For purposes of this section, "step therapy" means a  
111 protocol or program that establishes the specific sequence in which  
112 prescription drugs for a specified medical condition are to be  
113 prescribed.

114 [(b) (1)] (B) Notwithstanding the sixty-day period set forth in  
115 [subdivision (2) of subsection (a) of this section] subparagraph (A) of  
116 this subdivision, each insurance company, hospital service  
117 corporation, medical service corporation, health care center or other  
118 entity that uses step therapy for such prescription drugs shall establish  
119 and disclose to its health care providers a process by which an  
120 insured's treating health care provider may request at any time an  
121 override of the use of any step therapy drug regimen. Any such  
122 override process shall be convenient to use by health care providers  
123 and an override request shall be expeditiously granted when an  
124 insured's treating health care provider demonstrates that the drug  
125 regimen required under step therapy [(A)] (i) has been ineffective in  
126 the past for treatment of the insured's medical condition, [(B)] (ii) is  
127 expected to be ineffective based on the known relevant physical or  
128 mental characteristics of the insured and the known characteristics of  
129 the drug regimen, [(C)] (iii) will cause or will likely cause an adverse  
130 reaction by or physical harm to the insured, or [(D)] (iv) is not in the  
131 best interest of the insured, based on medical necessity.

132 [(2)] (C) Upon the granting of an override request, the insurance  
133 company, hospital service corporation, medical service corporation,  
134 health care center or other entity shall authorize dispensation of and  
135 coverage for the drug prescribed by the insured's treating health care  
136 provider, provided such drug is a covered drug under such policy or  
137 contract.

138 [(c)] (D) Nothing in this [section] subdivision shall [(1)] (i) preclude  
139 an insured or an insured's treating health care provider from  
140 requesting a review under sections 38a-591c to 38a-591g, inclusive, or  
141 [(2)] (ii) affect the provisions of section 38a-518i.

142     (b) The provisions of subdivision (2) of subsection (a) of this section  
143     shall not apply to a high deductible health plan, as that term is used in  
144     subsection (f) of section 38a-520, until after the minimum annual  
145     deductible for such plan has been met."

This act shall take effect as follows and shall amend the following sections:

Sec. 501	<i>January 1, 2016</i>	38a-510
Sec. 502	<i>January 1, 2016</i>	38a-544