Senate

General Assembly

File No. 443

February Session, 2016

Senate Bill No. 373

Senate, April 4, 2016

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT LIMITING CHANGES TO HEALTH INSURERS' PRESCRIPTION DRUG FORMULARIES.

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

Section 1. Section 38a-492f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), **[**and**]** (12) and (16) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for outpatient prescription drugs shall not **[**deny coverage for an insured for any drug that the insurer removes from its list of covered drugs, or otherwise ceases to provide coverage for, if (1) the insured was using the drug for the treatment of a chronic illness prior to the removal or cessation of coverage, (2) the insured was covered under the policy for the drug prior to the removal or cessation of coverage, and (3) the insured's attending health care provider states in writing, after the removal or cessation of coverage, that the drug is medically necessary

and lists the reasons why the drug is more medically beneficial than the drugs on the list of covered drugs. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies**]** remove any covered prescription drug from its list of covered drugs or reclassify or place such drug in a higher cost-sharing tier for the duration of the policy term, except a covered prescription drug may be removed from such list if such drug is identified as no longer safe and effective by the federal Food and Drug Administration or by peer-reviewed medical literature generally recognized by the relevant medical community. Nothing in this section shall be construed to prohibit the addition of prescription drugs to such policy's list of covered drugs during a policy term, provided such addition shall not affect the covered prescription drugs, or the classification or cost-sharing tier of such drugs, already on such list during such policy term.

Sec. 2. Section 38a-518f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), **[**and**]** (12) and (16) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for outpatient prescription drugs shall not **[**deny coverage for an insured for any drug that the insurer removes from its list of covered drugs, or otherwise ceases to provide coverage for, if (1) the insured was using the drug for the treatment of a chronic illness prior to the removal or cessation of coverage, (2) the insured was covered under the policy for the drug prior to the removal or cessation of coverage, and (3) the insured's attending health care provider states in writing, after the removal or cessation of coverage, that the drug is medically necessary and lists the reasons why the drug is more medically beneficial than the drugs on the list of covered drugs. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies**]** remove any covered prescription drug from its list of covered drugs or reclassify or place such drug in a higher cost-sharing tier for the duration of the

policy term, except a covered prescription drug may be removed from such list if such drug is identified as no longer safe and effective by the federal Food and Drug Administration or by peer-reviewed medical literature generally recognized by the relevant medical community. Nothing in this section shall be construed to prohibit the addition of prescription drugs to such policy's list of covered drugs during a policy term, provided such addition shall not affect the covered prescription drugs, or the classification or cost-sharing tier of such drugs, already on such list during such policy term.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2017*	38a-492f
Sec. 2	*January 1, 2017*	38a-518f

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 17 $	FY 18 $
State Comptroller - Fringe Benefits (Active State Employee and Retired State Employee Health Accounts)	GF&TF - Cost	None	Approximately $27.5 million

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 17 $	FY 18 $
Various Municipalities	STATE MANDATE - Cost	None	See Below

Explanation

The bill will result in an annual cost to the state employee and retiree health plan[1] starting in FY 18 of approximately $27.5 million based on the following factors: (1) $25 million related to prohibiting formulary changes during a policy term[2], (2) approximately $2 million from not covering generics as they become available, and (3) up to $500,000 in administrative expenses for the state's pharmacy benefit manager to administer a custom drug list.[3] The bill is not anticipated to result in increased costs to the state in FY 17 as the bill is not effective until 6 months into the fiscal year after the FY 17 policy is negotiated. The bill does not require the state to reopen a current

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

[2] This includes reductions in pharmacy rebates and savings on drug reclassifications. The state's pharmacy benefit manager currently makes quarterly updates to the plan's formulary.

[3] Estimate is based on the state plan's pharmacy expenditures and experience.

contract to comply with the provisions of the bill.

The bill will increase costs to certain fully insured municipal plans to comply with the provisions of the bill. The coverage requirements will result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2017. In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA).[4] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to changes in available drugs and drug formularies.

[4] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

OLR Bill Analysis

SB 373

AN ACT LIMITING CHANGES TO HEALTH INSURERS' PRESCRIPTION DRUG FORMULARIES.

SUMMARY:

This bill generally prohibits insurers and HMOs from removing from a formulary (i.e., a list of covered prescription drugs) or reclassifying any covered drug during a health insurance policy's term.

Specifically, under the bill, insurers and HMOs that cover outpatient prescription drugs cannot remove a covered drug from a formulary or reclassify a drug into a higher cost-sharing tier during a policy's term. However, they can remove a drug from a formulary if it is deemed no longer safe and effective by the U.S. Food and Drug Administration or peer-reviewed medical literature generally recognized by the relevant medical community. Additionally, the bill allows them to add drugs to the formulary during a policy term, as long as doing so does not affect the coverage or cost-sharing for drugs already on the formulary.

Current law allows insurers and HMOs to remove drugs from a formulary during a policy's term. But it prohibits them from denying coverage for any drug removed from the formulary if (1) the insured 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 drugs on the formulary.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including those provided under an HMO plan; or (5) ancillary services, such as

dental, vision, or prescription drugs. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit laws do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2017

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 11 Nay 7 (03/17/2016)