



INSURERS MAKING PRESCRIPTION DRUG FORMULARY CHANGES

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CONNECTICUT SB 373

[SB 373](#) (2016) limits when health insurers may change a prescription drug formulary (i.e., a list of covered prescription drugs) during a policy term. Under the bill, insurers may not remove a covered drug from a formulary or reclassify a drug into a higher cost-sharing tier during a health insurance policy's term. However, the bill allows insurers to remove a drug from a formulary at any time 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 insurers to add drugs to the formulary during a policy term, as long as doing so does not affect the coverage or cost-sharing requirements for drugs already on the formulary. (The bill died on the Senate calendar.)

ISSUES

Do other states limit the ability of health insurers to change their prescription drug formularies like [SB 373](#) (2016) proposed to do in Connecticut? How does Connecticut law protect insured people from formulary changes, and how is the law enforced?

SUMMARY

Louisiana, Nevada, and New Mexico limit when health insurers may remove a drug from, or otherwise change, their prescription drug formularies, according to the National Conference of State Legislatures. Louisiana and Nevada do so through regulations, while New Mexico's restrictions are contained in statute.

In Connecticut, insurers may remove drugs from a formulary during a policy's term. But the law prohibits them from denying coverage for any drug removed from the formulary if the (1) insured was using the drug to treat a chronic illness and it had been covered before the removal and (2) his or her attending physician states in writing that the drug is medically necessary and indicates why it is more beneficial than other drugs on the formulary (CGS §§ [38a-492f](#) and [38a-518f](#)).

According to the Connecticut Insurance Department, it monitors compliance with the law through its market conduct examinations and data calls (e.g., surveys) of regulated entities. During its current document retention period (2013 – 2016), the



department received one complaint against a company regarding compliance with this law. Upon the department's investigation of the complaint, the involved company complied and covered the person's chronic disease medication that had been removed from the company's formulary. But the department has not had to take administrative action against any company concerning this law specifically.

LOUISIANA

In Louisiana, a health insurer may modify a policy's drug coverage only at a policy's renewal and with approval by the insurance commissioner (La. Admin. Code tit. 37, pt. XIII, §§ 14111, 14115, & 14117). Modifying drug coverage includes:

1. removing a drug from a formulary;
2. adding a requirement that an enrollee receive prior authorization for a drug;
3. imposing or altering a quantity limit for a drug;
4. imposing a step-therapy restriction for a drug; or
5. moving a drug to a higher cost-sharing tier, unless a generic alternative is available.

A health insurer must submit a drug coverage modification to the insurance commissioner at least 120 days before the renewal date of the policy form. Once the commissioner approves the modification, the insurer must notify all affected enrollees at least 60 days before the date the modification is effective.

Louisiana's drug coverage modification requirements apply to both individual and group health insurance carriers.

NEVADA

Nevada generally prohibits a health insurer that offers an individual health benefit plan from removing a prescription drug from a formulary or moving a drug to a higher cost-sharing tier during the plan year (Nev. Admin. Code ch. 689A.xxx (R074-14)).

But the regulation allows an insurer to remove a drug from a formulary at any time if:

1. the drug is not approved by the U.S. Food and Drug Administration (FDA),
2. the FDA issues a statement questioning the drug's clinical safety, or

3. the FDA approves the drug for use without a prescription (i.e., as over-the-counter medication).

Additionally, the regulation allows an insurer to move a brand name drug to a higher cost-sharing tier if the insurer adds to the formulary an FDA-approved generic drug as an alternative. The generic must be available at a lower cost-sharing tier than the brand name drug.

NEW MEXICO

New Mexico generally limits when individual and group health insurance policies may change prescription drug coverage (N.M. Stat. Ann. § 59A-22-49.4). Changing drug coverage includes:

1. removing a drug from a formulary,
2. increasing the cost-sharing for a drug,
3. establishing a prior authorization requirement for a drug,
4. imposing or modifying a quantity limit for a drug,
5. imposing a step-therapy requirement for a drug, or
6. reclassifying a drug to a higher tier.

An insurer cannot make changes to a drug's coverage within 120 days of any previous change, unless a generic version of the drug is available. The insurer must also notify all affected enrollees at least 60 days before the date the modification is effective.

However, an insurer may, at any time and without prior notice, remove a drug from a formulary if FDA deems the drug unsafe or the drug has been removed from the market for any reason.

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