

## CGS § 38a-518f — Insurance Coverage for Certain Prescription Drugs Removed from a Formulary

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### Issues

Provide a legislative history of [CGS § 38a-518f](#) and answer specific questions about the statute. Additionally, address whether state law requires health insurers and HMOs (i.e., health carriers) to notify enrollees of prescription drug coverage changes, including formulary changes.

### Summary

[CGS § 38a-518f](#) prohibits certain group health insurance policies from denying coverage for a drug removed from the plan's formulary, or no longer covered by the health carrier, if (1) the covered enrollee was treating a chronic illness with the drug and it had been covered before the removal or cessation of coverage and (2) the enrollee's attending physician explains in writing, after the removal or cessation, that the drug is medically necessary and more medically beneficial than other drugs on the formulary. Coverage is subject to the same terms and conditions that apply to other benefits under the plan. ([CGS § 38a-492f](#) applies the same prohibition to individual health insurance policies.)

### *Formulary*

*A formulary is a list of prescription drugs that a health plan will cover.*

*As new drugs become available to consumers or the price of existing drugs change, health carriers may update their formularies by adding or removing drugs or moving drugs to different cost tiers.*

*Drugs placed in a higher tier may require an enrollee to (1) pay a higher out-of-pocket cost or (2) try a lower-tiered drug first before insurance covers the higher-tiered drug (i.e., step therapy).*

The law applies to 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; or (4) hospital or medical services, including those provided under an HMO plan.

The law, which passed during the 1999 regular legislative session and was enacted as [PA 99-284](#), was part of a larger bill, [HB 7032](#), about managed care organizations (MCOs). Public hearing testimony on the bill focused on the provision in it that dealt with a person's ability to sue an MCO if a decision made by the carrier was the proximate cause of an injury to the person.

The provision about insurance coverage for certain prescription drugs removed from a formulary was added to the bill as Section 38 of House Amendment A. The House and Senate passed the amended bill, and the governor signed it into law on July 7, 1999. The law took effect January 1, 2000 and was codified as [CGS § 38a-518f](#). Since then, the statute was amended once, by [PA 12-145](#) § 57, to make technical changes.

With regard to notification issues, state law does not require health carriers to notify enrollees of prescription drug coverage changes. In practice, carriers provide between 30 and 90 days' notice to impacted enrollees when there is a formulary change. Additionally, by law, carriers must provide enrollees with certain information upon enrollment in health plans, including whether a formulary is used and how to obtain information on which drugs are covered.

## **Legislative History of PA 99-284 § 38**

### ***Committee Action***

The Public Health Committee raised [HB 7032](#), which was enacted as [PA 99-284](#), in February 1999. The bill would have allowed MCOs to be held liable for damages when they fail to exercise ordinary care in making health care treatment decisions. It did not contemplate prescription drug coverage for drugs removed from a health carrier's formulary.

On March 23, 1999, the Public Health, Insurance and Real Estate, and Judiciary committees held a joint public hearing on the bill. Fourteen people spoke on the bill.

On April 13, 1999, the Public Health Committee reported a substitute bill, which made a number of changes concerning the operations, procedures, and regulation of MCOs and other health insurers. The House subsequently referred the substitute bill to numerous committees, which all reported

the bill without any changes. The committees and their vote dates are: Insurance and Real Estate (May 5, 1999), Government Administration and Elections (May 11, 1999), Judiciary (May 17, 1999), Appropriations (May 20, 1999), Human Services (May 28, 1999), and General Law (June 1, 1999).

### ***House Action***

The House took up the bill on June 8, 1999. Representative Eberle, the Public Health Committee chairwoman, introduced the bill and called House Amendment A, which she summarized. She stated that, among other things, the amendment included “some rules...for the protection of patients when formularies are changed” (House Transcript, page 6444). This was a reference to Section 38 of the amendment. Fourteen other representatives spoke on the amendment, though none commented on the formulary provision. The House adopted the amendment on a voice vote.

Eberle called and summarized House Amendment B, which made numerous minor changes to the bill as amended but did not change Section 38. Four other representatives spoke on the amendment, which the House adopted on a voice vote.

Representative Lockton and Representative Prelli called House amendments C and D, respectively, neither of which related to the formulary provision. Both amendments failed on voice votes.

The House passed the bill, as amended by House amendments A and B, by a roll call vote of 134 to 2, with 15 members absent and not voting.

### ***Senate Action***

The Senate took up the bill on June 9, 1999. Senator Harp, the Public Health Committee chairwoman, introduced the bill as amended by the House. She and 11 other senators spoke in favor of the bill. No one opposed it.

Senator Prague specifically spoke about Section 38 of the bill, saying it “clearly dictates that for those people who have been on a particular drug for a chronic illness [they] will continue to stay on that drug and that their insurance coverage cannot change because [the insurer] changed their formulary” (Senate Transcript, page 3857). She further noted that the bill requires the physician to document that the drug is medically necessary and “other drugs could not do what this drug is doing for that particular patient” (*id.*).

The Senate passed the bill in concurrence with the House by a roll call vote of 36 to 0.

## Questions Concerning CGS § 38a-518f

***Under CGS 38a-518f, is the burden on the health care provider to indicate why a patient should maintain a current drug treatment?***

The answer is yes. After the health carrier removes a drug from the formulary or otherwise ends coverage for it, the law requires an enrollee's attending health care provider to state in writing to the carrier that the drug is medically necessary for the patient and the reasons why it is more medically beneficial than other drugs included on the formulary.

***Does the statute prohibit a health carrier from making mid-year formulary changes? Does it prohibit a carrier from moving a drug to a different tier causing an increase in cost sharing (e.g., copayments)?***

The answer is no. The law does not prohibit a health carrier from making such changes. Contractually, a health carrier cannot change the copayments charged for a tier of drugs during a plan year. However, a carrier can change the tier a drug is on at any time, which could increase or decrease the drug's copayment.

***Does the statute require a health carrier to consult the attending provider before removing a drug from a formulary?***

The law does not require a carrier to consult with a patient's attending health care provider before removing a drug from a formulary. In practice, a health carrier that uses step therapy protocols (i.e., a program that establishes the specific sequence in which prescription drugs are to be prescribed) may require an enrollee to switch medications at the time a prescription is being filled. However, only a health care provider with prescribing authority may write a new prescription for the patient.

***Does CGS § 38a-518f require a health carrier to notify a patient or provider that the patient's medication is being switched and of the right to appeal such a decision?***

The answer is no. [CGS § 38a-518f](#) does not require notification to an impacted patient or provider. However, under a separate state law about the use of step therapy protocols, health carriers must disclose to providers the process by which providers may request an override of the use of a step

therapy regimen (CGS §§ [38a-510](#) and [38a-544](#)). Additionally, according to the Insurance Department, in practice, all carriers provide between 30 and 90 days' notice to impacted enrollees when there is a formulary change.

***Does CGS § 38a-518f require the Insurance Department to collect and report on the number of times health carriers change a formulary during a plan year and the potential savings or adverse impacts such changes have to the health care system and patients?***

The answer is no. The law does not require such data collection and reporting. However, the Insurance Department currently has proposed regulations (PR 2016-061) which include standards for formularies and pharmacy benefits. Among other things, the proposed regulation requires 60 days' advance notice to an enrollee when a formulary change occurs.

The department provided the following description of its current oversight of formularies and pharmacy benefits:

Consistent with the department's core mission of consumer protection, the department hired an additional examiner in early 2016 specifically to review formularies and pharmacy benefits. The department requires carriers to annually report to the department on their formularies and practices, including notice requirements. This review is part of the annual rate and form filing review. This information undergoes a comprehensive review by the department. The formulary information provided by carriers includes the frequency of formulary changes, both advantageous and non-advantageous. The department also requires that carriers disclose this information to their members. This information is required to be online and updated regularly. All policies are required to include an exception process for medically necessary drugs, including those not on the formulary, and information regarding prescription drug coverage and any utilization review standards. Policies must list the specific drugs that are subject to step therapy and how the exception process can be accessed for step therapy.

The department's Life and Health Unit reviews all of the information received to check for compliance with all state laws and regulations. The department's Market Conduct Unit reviews company practices during its regularly scheduled market conduct reviews. In addition, the department's Consumer Affairs Division refers complaint trends on formularies to the Market Conduct Unit for investigation as appropriate.

## **Related State Statutes**

State law does not require health carriers to notify enrollees of prescription drug coverage changes. As noted above, in practice, carriers provide between 30 and 90 days' notice to impacted enrollees when there is a formulary change.

State law does require carriers to provide consumers with certain information when they enroll in health plans. Specifically, beginning January 1, 2016, state law requires health carriers to make plan information available to consumers, including (1) any restrictions on the use or quantity of a covered prescription drug, (2) a description of out-of-pocket expenses applicable to prescription drugs, and (3) the specific copayment dollar amount and coinsurance percentage imposed on covered prescription drugs ([CGS § 38a-477d](#)). Additionally, the law requires health carriers to develop a way for consumers to determine if a specific prescription drug is included on the plan's formulary and if the drug is subject to preauthorization or step therapy requirements. Health carriers must make the information available to consumers at enrollment and on their websites.

State law also requires MCOs to provide every enrollee with a plan description, which must include, among other things, whether the plan uses a formulary or limits the availability of prescription drugs and how an enrollee can obtain information on which specific drugs are covered ([CGS § 38a-478g\(b\)\(5\)](#)).

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