OLR Bill Analysis

sHB 6096 (as amended by House "A")*

AN ACT LIMITING CHANGES TO PRESCRIPTION DRUG FORMULARIES AND LISTS OF COVERED DRUGS.

SUMMARY

This bill prohibits health carriers (e.g., insurers and HMOs) offering a health benefit plan that covers prescription drugs and uses a formulary (i.e., a list of covered prescription drugs) from removing from the formulary or moving to a higher cost-sharing tier, any covered drug during the plan year except as specifically allowed.

Under the bill, a carrier may remove a drug from a formulary with at least 90 days' advance notice to a covered person and his or her treating physician if the U.S. Food and Drug Administration (FDA):

1. questions the drug's clinical safety, unless the treating physician states in writing that the drug remains medically necessary for the covered person, or

2. approves the drug for over-the-counter use.

The bill allows a carrier to move a drug to a higher cost-sharing tier if it is available at $40 or less per month in any tier. It also allows a carrier to move a brand name drug to a higher cost-sharing tier if it adds an FDA-approved generic alternative to the formulary at a lower cost-sharing tier than the brand name drug.

Lastly, the bill explicitly allows a carrier to add a prescription drug to a formulary at any time.

*House Amendment "A" (1) replaces the original bill with similar provisions, (2) allows a carrier to move a drug to a higher cost-sharing tier if the drug is available for $40 or less in any tier, (3) adds the 90-day notice requirement, and (4) prohibits a carrier from removing a drug from a formulary if a treating physician indicates it is medically

necessary for a covered person.

EFFECTIVE DATE: January 1, 2020

APPLICABILITY OF BILL'S PROVISIONS

The bill generally applies to each insurer, HMO, hospital or medical service corporation, fraternal benefit society, or other entity that delivers, issues, renews, amends, or continues individual or group health insurance policies in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services. However, it does not apply to a grandfathered health plan, which is a plan that existed on March 23, 2010, that has not made significant coverage changes since.

Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Related Law

The law prohibits health carriers that cover outpatient prescription drugs from denying coverage for any drug removed from a formulary if (1) an insured person 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 formulary drugs (CGS §§ 38a-492f & 38a-518f).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 16 Nay 4 (03/19/2019)

Appropriations Committee

Joint Favorable
Yea 34 Nay 10 (05/13/2019)