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ResearchReport

Midyear Formulary Changes: Comparing Illinois Law to a Connecticut Proposal

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Issue

This report compares and summarizes Illinois Public Act (PA) 100-1052 (HB 4146 (2018)) and Connecticut's uncalled amendment LCO No. 4155 to SB 379 (2018), which did not become law. Both address health carriers' practice of changing formularies during a plan year.

Summary

Illinois' PA 100-1052 and Connecticut's proposed amendment to SB 379, LCO No. 4155 (2018), both address the practice of health carriers (i.e., insurers and HMOs) changing their prescription drug formularies during a plan year.

Both require carriers to give enrollees and health care providers 60 days' notice of a formulary change and allow enrollees currently using drugs to continue receiving coverage for them, if medically necessary, without any change in coverage level. They both also allow carriers to remove a drug from a formulary for safety reasons or if the manufacturer withdraws it from the market.

Formulary

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

As new drugs become available 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 pay a higher out-of-pocket cost.

For related information, see these OLR Reports:

2017-R-0202 and 2017-R-0203.

This report compares and summarizes each below.

Illinois Law Compared to Connecticut Proposal

Although the Illinois law and Connecticut proposed amendment vary in some respects, they share several provisions, as shown in Table 1.

Table 1: Comparing Illinois Law to Connecticut LCO No. 4155 (2018)

Provision	*Illinois PA 100-1052*	*Connecticut LCO No. 4155*
Requires 60 days' notice of formulary change to enrollees and providers	✓	✓
Allows covered enrollee currently using the drug to continue receiving drug at current coverage levels if medically necessary	✓	✓
Allows a health plan to remove a drug from a formulary if the FDA deems it not safe	✓	✓
Allows a health plan to remove a drug from a formulary if the manufacturer notifies FDA it plans to withdraw it from the market	✓	(not specified)
Allows a health plan to remove a drug from a formulary if the manufacturer withdrew it from the market	✓	✓
Allows a health plan to add a drug to the formulary during the plan year	✓	✓
Allows a health plan to require a pharmacist to substitute prescription drugs with biologics or generics	✓	(not specified)
Allows a provider to prescribe a different medically necessary drug included on the formulary	(not specified)	✓

Illinois

Beginning January 1, 2019, PA 100-1052 (which amends 215 Ill. Comp. Stat. 134/25) allows a health care plan to remove a drug from a formulary or negatively change its cost-sharing tier only if the plan gives covered enrollees, prospective enrollees, and certain health care providers 60 days' advanced notice of the formulary change.

Specifically, the health care plan must provide 60 days' notice of a formulary change as follows:

1. general notification to current and prospective enrollees;

2. direct notification to enrollees currently receiving coverage for the drug, including notice (a) of how to request an exception and (b) that a medical necessity certification from the prescribing health care provider will continue coverage of the drug at the existing coverage level; and

3. direct notification, either by first class mail or electronic means, to the prescribing provider of each enrollee affected by the proposed formulary change, including a form the provider can use to notify the plan (by mail or electronic means) that the drug is medically necessary for the enrollee.

If a provider submits a medical necessity certification to the health care plan, the plan must authorize coverage for the drug without any formulary changes (e.g., cannot increase cost sharing for the drug or move it to a more restrictive coverage tier).

However, the law allows a health care plan to remove a drug from a formulary or deny coverage for a drug if the (1) U.S. Food and Drug Administration (FDA) questions the drug's safety, (2) manufacturer notifies FDA of a planned or potential discontinuance of the drug, or (3) manufacturer has removed the drug from the market. It also allows a health care plan to add a prescription drug to its formulary during the plan year.

Additionally, the law allows a health care plan to require a pharmacist to substitute prescription drugs with interchangeable biologics or therapeutically equivalent generic drugs.

Connecticut

Current Law

Connecticut law prohibits individual and group health insurance policies from denying coverage for a drug a health carrier removes from the plan's formulary or no longer covers if (1) the covered enrollee was treating a chronic illness with the drug and it had been covered before the removal or coverage cessation 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 & 38a-518f).

Proposed Amendment LCO No. 4155 (2018)

LCO No. 4155 (2018), which did not become law, seeks to amend current law to further restrict a health carrier's ability to remove a drug from a formulary or reclassify a covered drug during a health insurance policy's term.

More specifically, the amendment prohibits individual and group health insurance policies, during a policy's term, from:

1. denying coverage for a drug the health carrier removes from its formulary or

2. reclassifying a drug to a higher (i.e., more expensive) cost-sharing tier if the policy imposes a cost-sharing requirement (e.g., coinsurance, copayment, or deductible) of more than $40 for a drug.

Under the amendment, these prohibitions apply only for a covered enrollee who was using the drug before the carrier removed or reclassified it. They do not apply if the enrollee's health care provider (1) attests in writing that the drug is no longer medically necessary or (2) prescribes another therapeutically equivalent drug included on the formulary.

Except for the above prohibitions, the amendment allows a health carrier to remove a drug from the formulary or reclassify a drug to a higher cost-sharing tier if the carrier gives 60 days' advanced written notice to covered enrollees and participating providers (i.e., health care providers included in the carrier's provider network).

Additionally, the amendment allows a health carrier to do the following:

1. remove a drug from the formulary if the FDA deems it no longer safe and effective or the FDA or manufacturer withdraws it from the market and

2. add a drug to the formulary, including a generic or multisource brand name drug that is therapeutically equivalent to a drug already on the formulary.

Lastly, the amendment specifies that it does not prohibit a health care provider from prescribing another drug included on the formulary that he or she deems medically necessary.

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