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

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

Section 1. (NEW) (Effective January 1, 2021) (a) For the purposes of this section:

(1) "Affordable Care Act" has the same meaning as provided in section 38a-1080 of the general statutes;

(2) "Health benefit plan" has the same meaning as provided in section 38a-1080 of the general statutes, except that such term shall not include a grandfathered health plan as such term is used in the Affordable Care Act; and

(3) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes.

(b) Notwithstanding any provision of the general statutes and except as provided in subsection (c) of this section, no health carrier offering a health benefit plan in this state on or after January 1, 2021, that includes

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a pharmacy benefit and uses a drug formulary or list of covered drugs may:

(1) Remove a prescription drug from the drug formulary or list of covered drugs during a plan year; or

(2) Move a prescription drug from a cost-sharing tier that imposes a lesser coinsurance, copayment or deductible for the prescription drug to a cost-sharing tier that imposes a greater coinsurance, copayment or deductible for the prescription drug during a plan year, unless the prescription drug is subject to an in-network coinsurance, copayment or deductible that is not greater than forty dollars per prescription per month in any tier.

(c) A health carrier offering a health benefit plan in this state on or after January 1, 2021, that includes a pharmacy benefit and uses a drug formulary or list of covered drugs may:

(1) Remove a prescription drug from the drug formulary or list of covered drugs, upon at least ninety days' advance notice to a covered person and the covered person's treating physician, if:

(A) The federal Food and Drug Administration issues an announcement, guidance, notice, warning or statement concerning the prescription drug that calls into question the clinical safety of the prescription drug, unless the covered person's treating physician states, in writing, that the prescription drug remains medically necessary despite such announcement, guidance, notice, warning or statement; or

(B) The prescription drug is approved by the federal Food and Drug Administration for use without a prescription; and

(2) Move a brand name prescription drug from a cost-sharing tier that imposes a lesser coinsurance, copayment or deductible for the brand name prescription drug to a cost-sharing tier that imposes a greater coinsurance, copayment or deductible for the brand name prescription drug if the health carrier adds to the drug formulary or list of covered
drugs a generic prescription drug that is:

(A) Approved by the federal Food and Drug Administration for use as an alternative to such brand name prescription drug; and

(B) In a cost-sharing tier that imposes a coinsurance, copayment or deductible for the generic prescription drug that is lesser than the coinsurance, copayment or deductible that is imposed for such brand name prescription drug.

(d) Nothing in this section shall prevent or prohibit a health carrier from adding a prescription drug to a formulary or list of covered drugs at any time.

This act shall take effect as follows and shall amend the following sections:

| Section 1 | January 1, 2021 | New section |

Statement of Purpose:
To limit the circumstances in which a health carrier may remove a prescription drug from a drug formulary or list of covered drugs, or move a prescription drug to a different cost-sharing tier, during a plan year.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]