OLR Bill Analysis

HB 6622 (as amended by House "A")*

AN ACT CONCERNING PRESCRIPTION DRUG FORMULARIES AND LISTS OF COVERED DRUGS.

SUMMARY

Beginning January 1, 2022, 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 (see below). This applies regardless of any other general statute provision (see BACKGROUND).

Additionally, the bill requires the Office of Health Strategy (OHS), at least annually, to conduct a study to determine the financial impact of the bill's requirements on the cost of commercial health plans in the state, including those offered and sold on the exchange (i.e., Access Health CT). Beginning by January 31, 2023, and annually thereafter, OHS must report the study results for the preceding year to the insurance commissioner and the Insurance and Real Estate Committee.

*House Amendment "A" adds the OHS study and reporting provisions.

EFFECTIVE DATE: January 1, 2022

PERMITTED FORMULARY CHANGES

Under the bill, a health carrier may remove a prescription 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. issues an announcement, guidance, or similar statement questioning 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 in-network for $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 specifies that it does not prevent or prohibit a carrier from adding a prescription drug to a formulary at any time.

APPLICABILITY OF THE 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 on or after January 1, 2022, 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, and 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
Yea 18 Nay 0 (03/22/2021)