



# House of Representatives

General Assembly

**File No. 348**

January Session, 2021

House Bill No. 6622

*House of Representatives, April 8, 2021*

The Committee on Insurance and Real Estate reported through REP. WOOD, K. of the 29th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

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

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

1 Section 1. Section 38a-1 of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective January 1, 2022*):

3 Terms used in this title and section 2 of this act, unless it appears from  
4 the context to the contrary, shall have a scope and meaning as set forth  
5 in this section.

6 (1) "Affiliate" or "affiliated" means a person that directly, or indirectly  
7 through one or more intermediaries, controls, is controlled by or is  
8 under common control with another person.

9 (2) "Alien insurer" means any insurer that has been chartered by or  
10 organized or constituted within or under the laws of any jurisdiction or  
11 country without the United States.

12 (3) "Annuities" means all agreements to make periodical payments

13 where the making or continuance of all or some of the series of the  
14 payments, or the amount of the payment, is dependent upon the  
15 continuance of human life or is for a specified term of years. This  
16 definition does not apply to payments made under a policy of life  
17 insurance.

18 (4) "Commissioner" means the Insurance Commissioner.

19 (5) "Control", "controlled by" or "under common control with" means  
20 the possession, direct or indirect, of the power to direct or cause the  
21 direction of the management and policies of a person, whether through  
22 the ownership of voting securities, by contract other than a commercial  
23 contract for goods or nonmanagement services, or otherwise, unless the  
24 power is the result of an official position with the person.

25 (6) "Domestic insurer" means any insurer that has been chartered by,  
26 incorporated, organized or constituted within or under the laws of this  
27 state.

28 (7) "Domestic surplus lines insurer" means any domestic insurer that  
29 has been authorized by the commissioner to write surplus lines  
30 insurance.

31 (8) "Foreign country" means any jurisdiction not in any state, district  
32 or territory of the United States.

33 (9) "Foreign insurer" means any insurer that has been chartered by or  
34 organized or constituted within or under the laws of another state or a  
35 territory of the United States.

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is  
37 unable to pay its obligations when they are due, or when its admitted  
38 assets do not exceed its liabilities plus the greater of: (A) Capital and  
39 surplus required by law for its organization and continued operation;  
40 or (B) the total par or stated value of its authorized and issued capital  
41 stock. For purposes of this subdivision "liabilities" shall include but not  
42 be limited to reserves required by statute or by regulations adopted by  
43 the commissioner in accordance with the provisions of chapter 54 or

44 specific requirements imposed by the commissioner upon a subject  
45 company at the time of admission or subsequent thereto.

46 (11) "Insurance" means any agreement to pay a sum of money,  
47 provide services or any other thing of value on the happening of a  
48 particular event or contingency or to provide indemnity for loss in  
49 respect to a specified subject by specified perils in return for a  
50 consideration. In any contract of insurance, an insured shall have an  
51 interest which is subject to a risk of loss through destruction or  
52 impairment of that interest, which risk is assumed by the insurer and  
53 such assumption shall be part of a general scheme to distribute losses  
54 among a large group of persons bearing similar risks in return for a  
55 ratable contribution or other consideration.

56 (12) "Insurer" or "insurance company" includes any person or  
57 combination of persons doing any kind or form of insurance business  
58 other than a fraternal benefit society, and shall include a receiver of any  
59 insurer when the context reasonably permits.

60 (13) "Insured" means a person to whom or for whose benefit an  
61 insurer makes a promise in an insurance policy. The term includes  
62 policyholders, subscribers, members and beneficiaries. This definition  
63 applies only to the provisions of this title and does not define the  
64 meaning of this word as used in insurance policies or certificates.

65 (14) "Life insurance" means insurance on human lives and insurances  
66 pertaining to or connected with human life. The business of life  
67 insurance includes granting endowment benefits, granting additional  
68 benefits in the event of death by accident or accidental means, granting  
69 additional benefits in the event of the total and permanent disability of  
70 the insured, and providing optional methods of settlement of proceeds.  
71 Life insurance includes burial contracts to the extent provided by  
72 section 38a-464.

73 (15) "Mutual insurer" means any insurer without capital stock, the  
74 managing directors or officers of which are elected by its members.

75 (16) "Person" means an individual, a corporation, a partnership, a  
76 limited liability company, an association, a joint stock company, a  
77 business trust, an unincorporated organization or other legal entity.

78 (17) "Policy" means any document, including attached endorsements  
79 and riders, purporting to be an enforceable contract, which  
80 memorializes in writing some or all of the terms of an insurance  
81 contract.

82 (18) "State" means any state, district, or territory of the United States.

83 (19) "Subsidiary" of a specified person means an affiliate controlled  
84 by the person directly, or indirectly through one or more intermediaries.

85 (20) "Unauthorized insurer" or "nonadmitted insurer" means an  
86 insurer that has not been granted a certificate of authority by the  
87 commissioner to transact the business of insurance in this state or an  
88 insurer transacting business not authorized by a valid certificate.

89 (21) "United States" means the United States of America, its territories  
90 and possessions, the Commonwealth of Puerto Rico and the District of  
91 Columbia.

92 Sec. 2. (NEW) (*Effective January 1, 2022*) (a) For the purposes of this  
93 section:

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

96 (2) "Health benefit plan" has the same meaning as provided in section  
97 38a-1080 of the general statutes, except that such term shall not include  
98 a grandfathered health plan as such term is used in the Affordable Care  
99 Act; and

100 (3) "Health carrier" has the same meaning as provided in section 38a-  
101 1080 of the general statutes.

102 (b) Notwithstanding any provision of the general statutes and except  
103 as provided in subsection (c) of this section, no health carrier offering a

104 health benefit plan in this state on or after January 1, 2022, that includes  
105 a pharmacy benefit and uses a drug formulary or list of covered drugs  
106 may:

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

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

116 (c) A health carrier offering a health benefit plan in this state on or  
117 after January 1, 2022, that includes a pharmacy benefit and uses a drug  
118 formulary or list of covered drugs may:

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

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

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

130 (2) Move a brand-name prescription drug from a cost-sharing tier  
131 that imposes a lesser coinsurance, copayment or deductible for the  
132 brand-name prescription drug to a cost-sharing tier that imposes a  
133 greater coinsurance, copayment or deductible for the brand-name  
134 prescription drug if the health carrier adds to the drug formulary or list

135 of covered drugs a generic prescription drug that is:

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

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2022</i>	38a-1
Sec. 2	<i>January 1, 2022</i>	New section

**INS**      *Joint Favorable*

*The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.*

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**OFA Fiscal Note**

**State Impact:** None

**Municipal Impact:**

<b>Municipalities</b>	<b>Effect</b>	<b>FY 22 \$</b>	<b>FY 23 \$</b>
Various Municipalities	Potential Cost	See Below	See Below

**Explanation**

The bill is not anticipated to result in a fiscal impact to the state employee and retiree health plan. The bill is not anticipated to materially modify the pharmacy benefit manager's administration of the plan's formulary compared to current practice given the \$40 copay cap in the bill.

The bill may increase costs to certain fully insured municipal plans to comply with the provisions of the bill if the plans are not otherwise excluded by the copay cap. There will be a cost to the extent the bill's provisions impact a municipal plan's ability to modify their formulary during a plan year. The coverage requirements will result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2022.

**The Out Years**

The annualized ongoing fiscal impact identified above would continue into the future subject to a change in the contracts or administration of fully insured municipal plans' prescription benefits.

**OLR Bill Analysis****HB 6622*****AN ACT CONCERNING 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. This applies regardless of any other general statute provision (see BACKGROUND).

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. 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.

EFFECTIVE DATE: January 1, 2022



## **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 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)