House of Representatives

File No. 753

General Assembly

January Session, 2021

(Reprint of File No. 348)

House Bill No. 6622
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 27, 2021

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:

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 Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

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

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

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

(3) "Annuities" means all agreements to make periodical payments where the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life or is for a specified term of years. This definition does not apply to payments made under a policy of life insurance.

(4) "Commissioner" means the Insurance Commissioner.

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

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

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

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

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

(10) "Insolvency" or "insolvent" means, for any insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (A) Capital and surplus required by law for its organization and continued operation; or (B) the total par or stated value of its authorized and issued capital stock. For purposes of this subdivision "liabilities" shall include but not

be limited to reserves required by statute or by regulations adopted by the commissioner in accordance with the provisions of chapter 54 or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

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

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

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

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

(15) "Mutual insurer" means any insurer without capital stock, the

managing directors or officers of which are elected by its members.

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

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

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

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

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

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

Sec. 2. (NEW) (*Effective January 1, 2022*) (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) "Exchange" has the same meaning as provided in section 38a-1080 of the general statutes;

(3) "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;

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

(5) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a of the general statutes; and

(6) "Qualified health plan" 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, 2022, 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 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, 2022, 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.

(e) (1) The Office of Health Strategy shall, at least annually, conduct a study to determine the impact that the requirements established in subsections (a) to (d), inclusive, of this section have on the cost of health benefit plans offered, delivered, issued for delivery, renewed, amended or continued in this state and qualified health plans offered and sold through the exchange.

(2) Not later than January 31, 2023, and annually thereafter, the Office of Health Strategy shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the commissioner and the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such report shall disclose

the results of the study conducted pursuant to subdivision (1) of this subsection for the preceding year.

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

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.

OFA Fiscal Note

State Impact: None

Municipal Impact:

Municipalities	Effect	FY 22 $	FY 23 $
Various Municipalities	Potential Cost	See Below	See Below

Explanation

The bill as amended will not 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 as amended 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.

House "A" requires the Office of Health Strategy to submit an annual study on the cost of implementing provisions of the bill and has no fiscal impact.

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 (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)