OLR Bill Analysis

sHB 6587 (as amended by House "A")*

AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR EPINEPHRINE CARTRIDGE INJECTORS.

SUMMARY

This bill (1) requires certain health insurance policies that cover outpatient prescription drugs to cover at least one epinephrine cartridge injector (e.g., EpiPen) and (2) limits an insured's cost sharing (e.g., copayment, coinsurance, or deductible) for the injector to no more than $25. (See below for the applicability of these provisions.)

By law, "epinephrine cartridge injector" means an automatic prefilled cartridge injector or similar automatic injectable equipment used to deliver epinephrine in a standard dose for an emergency first aid response to allergic reactions.

Under the bill, each contract between a health carrier (e.g., insurer or HMO) and a pharmacy benefits manager (PBM) that requires the PBM to administer a health care plan's pharmacy benefits on the carrier's behalf must also require the PBM, if it uses a tiered prescription drug formulary (i.e., list of covered drugs), to include at least one covered epinephrine cartridge injector in the lowest cost-sharing tier.

Lastly, the bill requires the Office of Health Strategy (OHS), at least annually, to conduct a study to determine the impact the bill's requirements have on the cost of affected health insurance policies, including qualified health plans offered on the exchange (i.e., Access Health CT). Beginning by January 31, 2023, OHS must annually report its findings to the insurance commissioner and the Insurance and Real Estate Committee.

*<u>House Amendment "A"</u> (1) specifies that affected insurance policies must cover at least one epinephrine cartridge injector and (2)

adds the PBM formulary and OHS provisions.

EFFECTIVE DATE: January 1, 2022

APPLICABILITY OF INSURANCE COVERAGE REQUIREMENT

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2022, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including those provided under an HMO plan; or (5) single service ancillary coverage, including prescription drug coverage. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

APPLICABILITY OF COST-SHARING PROVISION

The bill's cost-sharing provision applies to each plan described above. However, for plans that are high deductible health plans (HDHPs), it only applies to the maximum extent (1) permitted by federal law and (2) that does not disqualify someone who establishes a health savings account (HSA), medical savings account (MSA), or Archer MSA from receiving the associated federal tax benefits. Under federal law, individuals with eligible HDHPs may make pre-tax contributions to an HSA, MSA, or Archer MSA and use the account for qualified medical expenses.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 0 (03/22/2021)