General Assembly

Raised Bill No. 1003

January Session, 2021

LCO No. **3653**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT PROHIBITING CERTAIN HEALTH CARRIERS AND PHARMACY BENEFITS MANAGERS FROM EMPLOYING COPAY ACCUMULATOR PROGRAMS.

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 Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):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 sections 2, 4 and 5 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*) Each insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy in this state on or after January 1, 2022, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall, when calculating an insured's liability for a coinsurance, copayment, deductible or other out-of-pocket expense for a covered benefit, give credit for any payment made by a third party for the amount of, or any portion of the amount of, the coinsurance, copayment, deductible or other out-of-pocket expense for the covered benefit.

Sec. 3. Section 38a-478 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective January 1, 2022*):

As used in this section, sections 38a-478a to 38a-478o, inclusive, **[**and**]** subsection (a) of section 38a-478s and section 4 of this act:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Covered benefit" or "benefit" means a health care service to which an enrollee is entitled under the terms of a health benefit plan.

(3) "Enrollee" means a person who has contracted for or who participates in a managed care plan for such person or such person's eligible dependents.

(4) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

(5) "Managed care organization" means an insurer, health care center, hospital service corporation, medical service corporation or other organization delivering, issuing for delivery, renewing, amending or continuing any individual or group health managed care plan in this state.

(6) "Managed care plan" means a product offered by a managed care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through: (A) Arrangements with selected providers to furnish health care services; (B) explicit standards for the selection of participating providers; (C) financial incentives for enrollees to use the participating providers and procedures provided for by the plan; or (D) arrangements that share risks with providers, provided the organization offering a plan described under subparagraph (A), (B), (C) or (D) of this subdivision is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 and the plan includes utilization review, as defined in section 38a-591a.

(7) "Preferred provider network" has the same meaning as provided in section 38a-479aa.

(8) "Provider" or "health care provider" means a person licensed to provide health care services under chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

(9) "Utilization review" has the same meaning as provided in section 38a-591a.

(10) "Utilization review company" has the same meaning as provided in section 38a-591a.

Sec. 4. (NEW) (*Effective January 1, 2022*) For any contract delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, each managed care organization shall, when calculating an enrollee's liability for a coinsurance, copayment, deductible or other out-of-pocket expense for a covered benefit, give credit for any payment made by a third party for the amount of, or any portion of the amount of, the coinsurance, copayment, deductible or other out-of-pocket expense for the covered benefit.

Sec. 5. (NEW) (*Effective January 1, 2022*) On and after January 1, 2022, each contract entered into between a health carrier, as defined in section 38a-591a of the general statutes, and a pharmacy benefits manager, as defined in section 38a-479aaa of the general statutes, for the administration of the pharmacy benefit portion of a health benefit plan in this state on behalf of plan sponsors shall require that the pharmacy benefits manager, when calculating an insured's or enrollee's liability for a coinsurance, copayment, deductible or other out-of-pocket expense for a covered prescription drug benefit, give credit for any payment made by a third party for the amount of, or any portion of the amount of, the coinsurance, copayment, deductible or other out-of-pocket expense for the covered prescription drug benefit.

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
Sec. 3	*January 1, 2022*	38a-478

Sec. 4	*January 1, 2022*	New section
Sec. 5	*January 1, 2022*	New section

Statement of Purpose:

To require certain health carriers and pharmacy benefits managers to give credit for payments made by third parties for the amount of, or any portion of the amount of, an insured's or enrollee's cost-sharing liability for a covered benefit.

[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.]