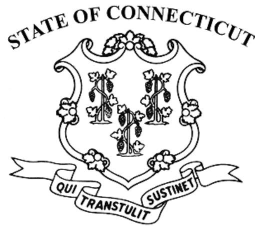

House of Representatives

File No. 793

General Assembly

January Session, 2021 **(Reprint of File No. 309)**

Substitute House Bill No. 6587
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
June 5, 2021

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR EPINEPHRINE CARTRIDGE INJECTORS, HEALTH CARRIERS, PHARMACY BENEFITS MANAGERS AND THE COST IMPACT OF CERTAIN MANDATED HEALTH INSURANCE BENEFITS.

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

1 Section 1. (NEW) (*Effective January 1, 2022*) (a) Each individual health
2 insurance policy providing coverage of the type specified in
3 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the
4 general statutes delivered, issued for delivery, renewed, amended or
5 continued in this state on or after January 1, 2022, that includes coverage
6 for outpatient prescription drugs shall provide coverage for at least one
7 epinephrine cartridge injector, as defined in section 19a-909 of the
8 general statutes.

9 (b) No policy described in subsection (a) of this section shall impose
10 a coinsurance, copayment, deductible or other out-of-pocket expense for
11 the epinephrine cartridge injector that such policy is required to cover

12 pursuant to said subsection (a) in an amount that is greater than twenty-
13 five dollars. The provisions of this subsection shall apply to a high
14 deductible health plan, as that term is used in subsection (f) of section
15 38a-493 of the general statutes, to the maximum extent permitted by
16 federal law, except if such plan is used to establish a medical savings
17 account or an Archer MSA pursuant to Section 220 of the Internal
18 Revenue Code of 1986, or any subsequent corresponding internal
19 revenue code of the United States, as amended from time to time, or a
20 health savings account pursuant to Section 223 of said Internal Revenue
21 Code, as amended from time to time, the provisions of this subsection
22 shall apply to such plan to the maximum extent that (1) is permitted by
23 federal law, and (2) does not disqualify such account for the deduction
24 allowed under said Section 220 or 223, as applicable.

25 Sec. 2. (NEW) (*Effective January 1, 2022*) (a) Each group health
26 insurance policy providing coverage of the type specified in
27 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the
28 general statutes delivered, issued for delivery, renewed, amended or
29 continued in this state on or after January 1, 2022, that includes coverage
30 for outpatient prescription drugs shall provide coverage for at least one
31 epinephrine cartridge injector, as defined in section 19a-909 of the
32 general statutes.

33 (b) No policy described in subsection (a) of this section shall impose
34 a coinsurance, copayment, deductible or other out-of-pocket expense for
35 the epinephrine cartridge injector that such policy is required to cover
36 pursuant to said subsection (a) in an amount that is greater than twenty-
37 five dollars. The provisions of this subsection shall apply to a high
38 deductible health plan, as that term is used in subsection (f) of section
39 38a-520 of the general statutes, to the maximum extent permitted by
40 federal law, except if such plan is used to establish a medical savings
41 account or an Archer MSA pursuant to Section 220 of the Internal
42 Revenue Code of 1986, or any subsequent corresponding internal
43 revenue code of the United States, as amended from time to time, or a
44 health savings account pursuant to Section 223 of said Internal Revenue
45 Code, as amended from time to time, the provisions of this subsection

46 shall apply to such plan to the maximum extent that (1) is permitted by
47 federal law, and (2) does not disqualify such account for the deduction
48 allowed under said Section 220 or 223, as applicable.

49 Sec. 3. Section 38a-479ooo of the general statutes is repealed and the
50 following is substituted in lieu thereof (*Effective January 1, 2022*):

51 For the purposes of this part <u>and section 4 of this act</u>:

52 (1) "Commissioner" means the Insurance Commissioner.

53 (2) "Department" means the Insurance Department.

54 (3) "Drug" has the same meaning as provided in section 21a-92.

55 (4) "Health care plan" means an individual or a group health
56 insurance policy that provides coverage of the types specified in
57 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 and includes
58 coverage for outpatient prescription drugs.

59 (5) "Health carrier" means an insurance company, health care center,
60 hospital service corporation, medical service corporation, fraternal
61 benefit society or other entity that delivers, issues for delivery, renews,
62 amends or continues a health care plan in this state.

63 (6) "Person" has the same meaning as provided in section 38a-1.

64 (7) "Pharmacist" has the same meaning as provided in section 38a-
65 479aaa.

66 (8) "Pharmacist services" has the same meaning as provided in section
67 38a-479aaa.

68 (9) "Pharmacy" has the same meaning as provided in section 38a-
69 479aaa.

70 (10) "Pharmacy benefits manager" or "manager" means any person
71 that administers the prescription drug, prescription device, pharmacist
72 services or prescription drug and device and pharmacist services

73 portion of a health care plan on behalf of a health carrier.

74 (11) (A) "Rebate" means a discount or concession, which affects the
75 price of an outpatient prescription drug, that a pharmaceutical
76 manufacturer directly provides to a (i) health carrier for an outpatient
77 prescription drug manufactured by the pharmaceutical manufacturer,
78 or (ii) pharmacy benefits manager after the manager processes a claim
79 from a pharmacy or a pharmacist for an outpatient prescription drug
80 manufactured by the pharmaceutical manufacturer.

81 (B) "Rebate" does not mean a bona fide service fee, as such term is
82 defined in Section 447.502 of Title 42 of the Code of Federal Regulations,
83 as amended from time to time.

84 (12) "Specialty drug" means a prescription outpatient specialty drug
85 covered under the Medicare Part D program established pursuant to
86 Public Law 108-173, the Medicare Prescription Drug, Improvement, and
87 Modernization Act of 2003, as amended from time to time, that exceeds
88 the specialty tier cost threshold established by the Centers for Medicare
89 and Medicaid Services.

90 Sec. 4. (NEW) (*Effective January 1, 2022*) On and after January 1, 2022,
91 each contract entered into between a health carrier and a pharmacy
92 benefits manager that requires the pharmacy benefits manager to
93 administer the prescription drug, prescription device, pharmacist
94 services or prescription drug and device and pharmacist services
95 portion of a health care plan on behalf of the health carrier shall, if the
96 pharmacy benefits manager utilizes a tiered prescription drug
97 formulary, require the pharmacy benefits manager to include at least
98 one covered epinephrine cartridge injector, as defined in section 19a-909
99 of the general statutes, in the cost-sharing tier that imposes the lowest
100 coinsurance, copayment, deductible or other out-of-pocket expense for
101 covered prescription drugs.

102 Sec. 5. (NEW) (*Effective January 1, 2022*) (a) For the purposes of this
103 section:

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

106 (2) "Exchange" has the same meaning as provided in section 38a-1080
107 of the general statutes;

108 (3) "Health benefit plan" has the same meaning as provided in section
109 38a-1080 of the general statutes, except that such term shall not include
110 a grandfathered health plan as such term is used in the Affordable Care
111 Act;

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

114 (5) "Qualified health plan" has the same meaning as provided in
115 section 38a-1080 of the general statutes.

116 (b) The Office of Health Strategy shall, at least annually, conduct a
117 study to determine the impact that:

118 (1) The requirements established in section 1 of this act have on the
119 cost of the individual health insurance policies that are subject to such
120 requirements;

121 (2) The requirements established in section 2 of this act have on the
122 cost of the group health insurance policies that are subject to such
123 requirements; and

124 (3) The requirements established in section 4 of this act have on the
125 cost of health benefit plans offered, delivered, issued for delivery,
126 renewed, amended or continued in this state and qualified health plans
127 offered and sold through the exchange.

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

133 report shall disclose the results of the study conducted pursuant to
134 subsection (b) of this section for the preceding year.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2022*	New section
Sec. 2	*January 1, 2022*	New section
Sec. 3	*January 1, 2022*	38a-479ooo
Sec. 4	*January 1, 2022*	New section
Sec. 5	*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

There is no fiscal impact to the State resulting from the bill, which requires that epinephrine cartridge injectors be covered under certain health insurance policies at a total out of pocket cost of $25 or less. The state employee and retiree health plans already provide coverage in accordance with the bill[1].

The bill may result in a potential cost to fully-insured municipalities, to the extent that providing coverage below the out-of-pocket threshold may increase premiums reflected in plan years beginning on and after January 1, 2022. The cost relative to the overall premium is anticipated to be minimal.

The bill also requires the Office of Health Strategy to annually study the impact the bill has on the cost of health insurance policies. It is anticipated that the agency can conduct this study within existing resources.

[1] Pursuant to federal law, self-insured plans are exempt from state health mandates. However, the state employee and retiree plan has traditionally such adopted mandates.

House "A" struck the underlying bill and results in the fiscal impact described above.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

The preceding Fiscal Impact statement is prepared for the benefit of the members of the General Assembly, solely for the purposes of information, summarization and explanation and does 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.

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.

*House Amendment "A" (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)