House of Representatives

File No. 580

General Assembly

February Session, 2022 ***(Reprint of File No. 374)***

Substitute House Bill No. 5386
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 21, 2022

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR EPINEPHRINE CARTRIDGE INJECTORS, HEALTH CARRIERS AND PHARMACY BENEFIT MANAGERS.

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

Section 1. (NEW) (*Effective January 1, 2023*) (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2023, that includes coverage for outpatient prescription drugs shall provide coverage for at least one epinephrine cartridge dual-pack injector. For the purposes of this section and sections 2 and 4 of this act, "epinephrine cartridge injector" means a dual-pack containing automatic, prefilled cartridge injectors or similar automatic injectable equipment used to deliver epinephrine in a standard dose for an emergency first aid response to allergic reactions.

(b) No policy described in subsection (a) of this section shall impose

a coinsurance, copayment, deductible or other out-of-pocket expense for the epinephrine cartridge injector that such policy is required to cover pursuant to said subsection (a) in an amount that is greater than twenty-five dollars. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time. The provisions of this subsection shall apply to such high deductible health plans to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under Section 220 or 223, of the Internal Revenue Code of 1986, as applicable.

Sec. 2. (NEW) (*Effective January 1, 2023*) (a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2023, that includes coverage for outpatient prescription drugs shall provide coverage for at least one epinephrine cartridge injector.

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

health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time. The provisions of this subsection shall apply to such high deductible health plans to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under Section 220 or 223, of said Internal Revenue Code of 1986, as applicable.

Sec. 3. Section 38a-479ooo of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2023*):

For the purposes of this part and section 4 of this act:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Department" means the Insurance Department.

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

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

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

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

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

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

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

(10) "Pharmacy benefits manager" or "manager" means any person that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health care plan on behalf of a health carrier.

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

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

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

Sec. 4. (NEW) (*Effective January 1, 2023*) On or after January 1, 2023, each contract entered into between a health carrier and a pharmacy benefits manager that requires the pharmacy benefits manager to administer the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health care plan on behalf of the health carrier shall, if the pharmacy benefits manager utilizes a tiered prescription drug formulary, require the pharmacy benefits manager to include at least one covered epinephrine cartridge injector in the cost-sharing tier that imposes the lowest coinsurance, copayment, deductible or other out-of-pocket expense for covered prescription drugs.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2023*	New section
Sec. 2	*January 1, 2023*	New section
Sec. 3	*January 1, 2023*	38a-479ooo
Sec. 4	*January 1, 2023*	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 23 $	FY 24 $
Various Municipalities	STATE MANDATE[1] - 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. 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, 2023.

In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA). It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, municipalities with self-insured plans are

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

exempt from state insurance mandates.

House Amendment "A" revises the definition of "epinephrine cartridge injector" which did not alter the municipal fiscal impact described above.

The Out Years

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

OLR Bill Analysis

sHB 5386 (as amended by House "A")*

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR EPINEPHRINE CARTRIDGE INJECTORS, HEALTH CARRIERS AND PHARMACY BENEFIT MANAGERS.

SUMMARY

This bill (1) requires certain individual and group health insurance policies that cover outpatient prescription drugs to cover at least one epinephrine cartridge (dual-pack) injector (e.g., EpiPen) and (2) caps an insured's cost sharing (e.g., copayment, coinsurance, or deductible) for the injector at $25. (It is unclear if the coverage requirement is for at least one injector dual pack each year or for some other time period.)

Under the bill, an "epinephrine cartridge injector" is a dual pack of automatic prefilled cartridge injectors or similar automatic injectable equipment used to deliver epinephrine in a standard dose as an emergency first aid response to allergic reactions.

Additionally, the bill requires 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 to also require the PBM to include at least one covered epinephrine cartridge injector in the lowest cost-sharing tier if it uses a tiered prescription drug formulary (i.e., list of covered drugs).

*House Amendment "A" revises the definition of "epinephrine cartridge injector" to specify that it is a dual pack of injectors that deliver epinephrine.

EFFECTIVE DATE: January 1, 2023

APPLICABILITY OF INSURANCE COVERAGE REQUIREMENT

The bill's coverage requirement applies to fully-insured individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2023, 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 LIMITATION

The bill's cost-sharing limitation applies to each plan described above. However, for plans that are high deductible health plans (HDHPs), it applies only 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 16 Nay 1 (03/22/2022)

Appropriations Committee

Joint Favorable
Yea 48 Nay 0 (04/18/2022)