Proposed Amendments to NCOIL Accumulator Adjustment Program Model Act

Section 2

Delete (I) – "The legislature further finds that accumulator adjustment programs allow health insurers and PBMs to "double dip" by accepting funds from both the cost sharing assistance program and the patient beyond the original deductible amount and the annual out-of-pocket limit."

Section 3

Add definition of "Generic Equivalent"

(D) "Generic Equivalent":

> (i) means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States Pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects.
>
> (ii) does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the Administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

Revised Section 4

(A) When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [CARRIER/INSURER/ISSUER] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person for a prescription drug that is either:

> (1) without a generic equivalent; or
>
> (2) with a generic equivalent where the enrollee has obtained access to the prescription drug through any of the following:

(a) prior authorization

(b) a step therapy protocol

(c) the health care insurer's exceptions and appeals process

(B) A person that pays any amount on behalf of an enrollee for a covered prescription drug:

(1) must notify the enrollee prior to the acceptance of the financial assistance of the total amount of assistance available and the duration for which it is available; and

(2) may not condition the assistance on enrollment in a specific health plan or type of health plan, to the extent permitted under federal law.

(C) If under federal law, application of subsection (A) would result in Health Savings Account ineligibility under section 223 of the federal Internal Revenue Code, this requirement shall apply only, for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of subsection (A) shall apply regardless of whether the minimum deductible under section 223 has been satisfied.