BCBSA Proposed Amendments – 11.15.2021

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National Council of Insurance Legislators (NCOIL)

Accumulator Adjustment Program Model Act

***Sponsored by Sen. Jason Rapert (AR)**
***Rep. Deborah Ferguson (AR); Rep. George Keiser (ND); Asw. Pam Hunter (NY) – Co-Sponsors**

***Draft as of June 15th, 2021.**

To be discussed and considered during the Health Insurance & Long Term Care Issues Committee meeting on November 18, 2021~~July 17, 2021.~~

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Section 1. Title

This Act shall be known and may be cited as the "[State] Accumulator Adjustment Program Act."

Section 2. Legislative Purpose

(A) The legislature finds that cost sharing assistance is indispensable to help many patients with rare, serious, and chronic diseases afford out-of-pocket costs for their essential, often lifesaving, medications.

(B) The legislature further finds that patients need cost sharing assistance because of the high out-of-pocket cost of medications.

(C) The legislature further finds that when patients face unexpected charges during the plan year, they are less likely to adhere to their medication regimen.

(D) The legislature further finds that lack of patient adherence to needed medicines leads to potential negative health consequences for the patients, such as unnecessary emergency room visits, doctors' visits, surgeries, and other interventions.

(E) The legislature further finds that patients are only able to use cost sharing assistance after they have met requirement(s) for coverage of their medication. Requirements for coverage can include the medication's inclusion on the patient's formulary and utilization management protocols, such as prior authorization and step therapy.

(F) The legislature further finds that health insurers and pharmacy benefit managers (PBMs) have implemented programs, such as accumulator adjustment programs, to restrict cost sharing assistance from counting towards a patient's deductible or annual out-of-pocket limit.

(G) The legislature further finds that as a result of an accumulator adjustment program, a patient is required to continue to make payments even if the patient has already hit an out-of-pocket limit when including cost sharing assistance. As such, the cost sharing assistance depletes leaving the patient responsible for paying the full deductible and meeting the annual out-of-pocket limit for a second time. This means accumulator adjustment programs limit the benefit patients receive from copay assistance programs.

(H) The legislature further finds that patients often are not aware of the inclusion of accumulator adjustment programs in their health plan contracts. Patients tend to learn about these types of programs when they attempt to obtain their medication after their cost sharing assistance has run out, whether at the pharmacy, infusion center, or at home through the mail.

(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.

(J) Therefore, the legislature declares it a matter of public interest that health insurers and PBMs must count any amount paid by the patient or on behalf of the patient by another person towards a patient's annual out-of-pocket limit and any cost sharing requirement, such as deductibles.

Section 3. Definitions

(A) "Cost sharing" means any copayment, coinsurance, deductible, or annual limitation on cost sharing (including but not limited to a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan, whether covered under the medical or pharmacy benefit.

(B) "Carrier" OR "Insurer" OR "Issuer" means [cross-reference state insurance statutes and use their existing definitions], and shall include, but not be limited to any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health benefit plan offered by public and private entities. For the purposes of this section, "insurer" does not include self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Pub.L. 93–406, 88 Stat. 829, as amended).

(C) "Commissioner" means the state insurance commissioner.

(D) "Health Plan" means a policy, contract, certificate, or subscriber agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(E) "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

(F) "Pharmacy Benefit Manager" means any person or business who administers the prescription drug or device program of one or more health plans on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

Drafting Note: Use existing statutory definitions of "health plan" and "pharmacy benefit manager" when possible.

Drafting Note: If "person" is already in the state's definition, that includes corporation. Otherwise, can remove "by another person."

Section 4. Cost-Sharing and Reporting Requirements

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. A [CARRIER/INSURER/ISSUER] may exclude cost-sharing for a drug paid on behalf of the enrollee by another person if a clinically-appropriate generic or biosimilar of that drug is available. When a clinically-appropriate generic or biosimilar is available and a brand name drug or reference biologic continues to be purchased, the pharmacy benefit manager shall include cost-sharing that would be paid by the enrollee or paid on behalf of the enrollee for that generic or biosimilar.

(A) Drug manufacturers shall report to the [State] Department of Insurance or state entity charged with overseeing drug affordability for commercially insured individuals and groups

a. the total value of coupons, discounts, copayment assistance or other reduction in costs provided to consumers in [State] who participate in patient assistance program[s] offered by the manufacturer.

b. the total annual financial assistance provided to each entity or nonprofit providing copayment assistance.

(B) Drug manufacturers that make available coupons, discounts, copayment assistance or other reductions in cost to an insured shall:

a. Offer the assistance for the duration of the plan year;

b. provide notification to consumer and carrier if the assistance will be discontinued for a subsequent plan year;

c. not limit assistance to enrollment in a specific health plan or type of health plan; and

d. permit such mechanism to be used by a person without health insurance coverage.

Section 5. Rules

The commissioner shall promulgate rules necessary to carry out this Act.

Section 6. Enactment

(A) This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 202##.