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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*

**Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on November 18, 2021 and the NCOIL Executive Committee on November 20, 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) 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) “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.

(E) “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.

(F) “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.

(G) “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 Requirements

(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.

Section 5. Rules

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

Section 6. Enactment

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