First Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 23-0913.01 Christy Chase x2008 **SENATE BILL 23-195**

SENATE SPONSORSHIP

Winter F. and Will,

HOUSE SPONSORSHIP

Jodeh and Pugliese, Hartsook

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

101 CONCERNING THE CALCULATION OF CONTRIBUTIONS TOWARD AN
102 INSURED'S REQUIRED COST SHARING UNDER A HEALTH
103 COVERAGE PLAN.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill requires a health insurer or pharmacy benefit manager to include in the calculation of a covered person's contributions toward cost-sharing requirements, including any annual limitation on a covered person's out-of-pocket costs, any payments made by or on behalf of the covered person.

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing law.
Dashes through the words or numbers indicate deletions from existing law.

1 *Be it enacted by the General Assembly of the State of Colorado:*
2 **SECTION 1. Legislative declaration.** (1) The general assembly
3 finds and declares that:
4 (a) Cost-sharing assistance is indispensable in helping many
5 patients with rare, serious, and chronic diseases afford out-of-pocket costs
6 for their essential, often life-saving, medications;
7 (b) Patients need cost-sharing assistance because of the high
8 out-of-pocket cost of medications;
9 (c) When patients face unexpected charges during the plan year,
10 they are less likely to adhere to their medication regimen;
11 (d) Lack of patient adherence to their necessary medication
12 regimen leads to potential negative health consequences for patients, such
13 as unnecessary emergency room visits, doctors' visits, surgeries, and other
14 interventions;
15 (e) Patients are only able to use cost-sharing assistance after they
16 have met requirements for coverage of their medication, which
17 requirements can include that the medication is included on the drug
18 formulary in the patient's health coverage plan and compliance with
19 utilization management protocols, such as prior authorization and step
20 therapy;
21 (f) Health insurers and pharmacy benefit managers (PBMs) have
22 implemented programs, such as accumulator adjustment programs, that
23 restrict the applicability of cost-sharing assistance toward a deductible or
24 an annual out-of-pocket limit under a patient's health coverage plan;
25 (g) As a result of an accumulator adjustment program, a patient
26 is required to continue to make out-of-pocket payments, even if the

1 patient would have reached the out-of-pocket limit if amounts received
2 through cost-sharing assistance were counted toward the out-of-pocket
3 limit under the patient's health coverage plan;

4 (h) By excluding cost-sharing assistance from a patient's
5 deductible and annual out-of-pocket limit, an accumulator adjustment
6 program makes the patient responsible for paying the full deductible
7 under the patient's plan and for meeting the annual out-of-pocket limit for
8 a second time, thus limiting or eliminating the benefit the patient receives
9 from a cost-sharing assistance program;

10 (i) Most patients are not aware of the inclusion of accumulator
11 adjustment programs in their health coverage plans and often learn about
12 these types of programs when they attempt to obtain their medication
13 after their cost-sharing assistance has been exhausted, whether at a
14 pharmacy, an infusion center, or at home through the mail; and

15 (j) Accumulator adjustment programs allow health insurers and
16 PBMs to "double dip" by accepting funds from both the cost-sharing
17 assistance program and the patient beyond the original deductible amount
18 and the annual out-of-pocket limit.

19 (2) Therefore, the general assembly declares it a matter of public
20 interest to require health insurers and PBMs to count any amount paid by
21 the patient or on behalf of the patient by another person, including
22 through a cost-sharing assistance program, toward the patient's annual
23 out-of-pocket limit and any cost-sharing requirement, such as deductibles,
24 under the patient's health coverage plan.

25 **SECTION 2.** In Colorado Revised Statutes, **add** 10-16-158 as
26 follows:

27 **10-16-158. Calculation of contribution to out-of-pocket and**

1 **cost-sharing requirements - exception - definition.** (1) WHEN
2 CALCULATING A COVERED PERSON'S OVERALL CONTRIBUTION TO AN
3 OUT-OF-POCKET MAXIMUM OR COST-SHARING REQUIREMENT UNDER THE
4 COVERED PERSON'S HEALTH COVERAGE PLAN, A CARRIER OR PBM SHALL
5 INCLUDE ANY AMOUNT PAID BY THE COVERED PERSON OR BY ANOTHER
6 PERSON ON BEHALF OF THE COVERED PERSON.
7 (2) IF APPLICATION OF SUBSECTION (1) OF THIS SECTION WOULD
8 MAKE A COVERED PERSON'S HEALTH SAVINGS ACCOUNT CONTRIBUTIONS
9 INELIGIBLE UNDER SECTION 223 OF THE FEDERAL "INTERNAL REVENUE
10 CODE OF 1986", 26 U.S.C. SEC. 223, AS AMENDED, SUBSECTION (1) OF THIS
11 SECTION APPLIES TO THE DEDUCTIBLE APPLICABLE TO THE COVERED
12 PERSON'S HEALTH COVERAGE PLAN AFTER THE COVERED PERSON HAS
13 SATISFIED THE MINIMUM DEDUCTIBLE AMOUNT UNDER 26 U.S.C. SEC. 223;
14 EXCEPT THAT, WITH RESPECT TO ITEMS OR SERVICES THAT ARE
15 PREVENTIVE CARE PURSUANT TO 26 U.S.C. SEC. 223 (c)(2)(C),
16 SUBSECTION (1) OF THIS SECTION APPLIES, REGARDLESS OF WHETHER THE
17 MINIMUM DEDUCTIBLE UNDER 26 U.S.C. SEC. 223 HAS BEEN SATISFIED.
18 (3) AS USED IN THIS SECTION, "COST-SHARING REQUIREMENT"
19 MEANS ANY COPAYMENT, COINSURANCE, DEDUCTIBLE, OR ANNUAL
20 LIMITATION ON COST SHARING, INCLUDING A LIMITATION SUBJECT TO 42
21 U.S.C. SEC. 18022 (c) OR 42 U.S.C. SEC. 300gg-6 (b), REQUIRED BY OR ON
22 BEHALF OF A COVERED PERSON IN ORDER TO RECEIVE A SPECIFIC
23 HEALTH-CARE SERVICE, INCLUDING A PRESCRIPTION DRUG OR DEVICE,
24 COVERED BY THE COVERED PERSON'S HEALTH COVERAGE PLAN, WHETHER
25 COVERED AS A MEDICAL OR PHARMACY BENEFIT.
26 **SECTION 3. Act subject to petition - effective date -**
27 **applicability.** (1) This act takes effect at 12:01 a.m. on the day following

1 the expiration of the ninety-day period after final adjournment of the
2 general assembly; except that, if a referendum petition is filed pursuant
3 to section 1 (3) of article V of the state constitution against this act or an
4 item, section, or part of this act within such period, then the act, item,
5 section, or part will not take effect unless approved by the people at the
6 general election to be held in November 2024 and, in such case, will take
7 effect on the date of the official declaration of the vote thereon by the
8 governor.
9 (2) This act applies to health coverage plans issued or renewed on
10 or after January 1, 2025.