



General Assembly

February Session, 2020

**Raised Bill No. 336**

LCO No. 1983



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

***AN ACT PROHIBITING CERTAIN HEALTH CARRIERS AND  
PHARMACY BENEFITS MANAGERS FROM EMPLOYING COPAY  
ACCUMULATOR PROGRAMS.***

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

1 Section 1. Section 38a-1 of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective January 1, 2021*):

3 Terms used in this title and sections 2, 4 and 5 of this act, unless it  
4 appears from the context to the contrary, shall have a scope and  
5 meaning as set forth in this section.

6 (1) "Affiliate" or "affiliated" means a person that directly, or indirectly  
7 through one or more intermediaries, controls, is controlled by or is  
8 under common control with another person.

9 (2) "Alien insurer" means any insurer that has been chartered by or  
10 organized or constituted within or under the laws of any jurisdiction or  
11 country without the United States.

12 (3) "Annuities" means all agreements to make periodical payments

13 where the making or continuance of all or some of the series of the  
14 payments, or the amount of the payment, is dependent upon the  
15 continuance of human life or is for a specified term of years. This  
16 definition does not apply to payments made under a policy of life  
17 insurance.

18 (4) "Commissioner" means the Insurance Commissioner.

19 (5) "Control", "controlled by" or "under common control with" means  
20 the possession, direct or indirect, of the power to direct or cause the  
21 direction of the management and policies of a person, whether through  
22 the ownership of voting securities, by contract other than a commercial  
23 contract for goods or nonmanagement services, or otherwise, unless the  
24 power is the result of an official position with the person.

25 (6) "Domestic insurer" means any insurer that has been chartered by,  
26 incorporated, organized or constituted within or under the laws of this  
27 state.

28 (7) "Domestic surplus lines insurer" means any domestic insurer that  
29 has been authorized by the commissioner to write surplus lines  
30 insurance.

31 (8) "Foreign country" means any jurisdiction not in any state, district  
32 or territory of the United States.

33 (9) "Foreign insurer" means any insurer that has been chartered by or  
34 organized or constituted within or under the laws of another state or a  
35 territory of the United States.

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is  
37 unable to pay its obligations when they are due, or when its admitted  
38 assets do not exceed its liabilities plus the greater of: (A) Capital and  
39 surplus required by law for its organization and continued operation;  
40 or (B) the total par or stated value of its authorized and issued capital  
41 stock. For purposes of this subdivision "liabilities" shall include but not  
42 be limited to reserves required by statute or by regulations adopted by

43 the commissioner in accordance with the provisions of chapter 54 or  
44 specific requirements imposed by the commissioner upon a subject  
45 company at the time of admission or subsequent thereto.

46 (11) "Insurance" means any agreement to pay a sum of money,  
47 provide services or any other thing of value on the happening of a  
48 particular event or contingency or to provide indemnity for loss in  
49 respect to a specified subject by specified perils in return for a  
50 consideration. In any contract of insurance, an insured shall have an  
51 interest which is subject to a risk of loss through destruction or  
52 impairment of that interest, which risk is assumed by the insurer and  
53 such assumption shall be part of a general scheme to distribute losses  
54 among a large group of persons bearing similar risks in return for a  
55 ratable contribution or other consideration.

56 (12) "Insurer" or "insurance company" includes any person or  
57 combination of persons doing any kind or form of insurance business  
58 other than a fraternal benefit society, and shall include a receiver of any  
59 insurer when the context reasonably permits.

60 (13) "Insured" means a person to whom or for whose benefit an  
61 insurer makes a promise in an insurance policy. The term includes  
62 policyholders, subscribers, members and beneficiaries. This definition  
63 applies only to the provisions of this title and does not define the  
64 meaning of this word as used in insurance policies or certificates.

65 (14) "Life insurance" means insurance on human lives and insurances  
66 pertaining to or connected with human life. The business of life  
67 insurance includes granting endowment benefits, granting additional  
68 benefits in the event of death by accident or accidental means, granting  
69 additional benefits in the event of the total and permanent disability of  
70 the insured, and providing optional methods of settlement of proceeds.  
71 Life insurance includes burial contracts to the extent provided by  
72 section 38a-464.

73 (15) "Mutual insurer" means any insurer without capital stock, the  
74 managing directors or officers of which are elected by its members.

75 (16) "Person" means an individual, a corporation, a partnership, a  
76 limited liability company, an association, a joint stock company, a  
77 business trust, an unincorporated organization or other legal entity.

78 (17) "Policy" means any document, including attached endorsements  
79 and riders, purporting to be an enforceable contract, which  
80 memorializes in writing some or all of the terms of an insurance  
81 contract.

82 (18) "State" means any state, district, or territory of the United States.

83 (19) "Subsidiary" of a specified person means an affiliate controlled  
84 by the person directly, or indirectly through one or more intermediaries.

85 (20) "Unauthorized insurer" or "nonadmitted insurer" means an  
86 insurer that has not been granted a certificate of authority by the  
87 commissioner to transact the business of insurance in this state or an  
88 insurer transacting business not authorized by a valid certificate.

89 (21) "United States" means the United States of America, its territories  
90 and possessions, the Commonwealth of Puerto Rico and the District of  
91 Columbia.

92 Sec. 2. (NEW) (*Effective January 1, 2021*) Each insurer, health care  
93 center, hospital service corporation, medical service corporation,  
94 fraternal benefit society or other entity that delivers, issues for delivery,  
95 renews, amends or continues an individual or group health insurance  
96 policy in this state on or after January 1, 2021, providing coverage of the  
97 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
98 of the general statutes shall, when calculating an insured's liability for a  
99 coinsurance, copayment, deductible or other out-of-pocket expense for  
100 a covered benefit, give credit for any payment made by a third party for  
101 the amount of, or any portion of the amount of, the coinsurance,  
102 copayment, deductible or other out-of-pocket expense for the covered  
103 benefit.

104 Sec. 3. Section 38a-478 of the general statutes is repealed and the

105 following is substituted in lieu thereof (*Effective January 1, 2021*):

106 As used in this section, sections 38a-478a to 38a-478o, inclusive, [and]  
107 subsection (a) of section 38a-478s, and section 4 of this act:

108 (1) "Commissioner" means the Insurance Commissioner.

109 (2) "Covered benefit" or "benefit" means a health care service to which  
110 an enrollee is entitled under the terms of a health benefit plan.

111 (3) "Enrollee" means a person who has contracted for or who  
112 participates in a managed care plan for such person or such person's  
113 eligible dependents.

114 (4) "Health care services" means services for the diagnosis,  
115 prevention, treatment, cure or relief of a health condition, illness, injury  
116 or disease.

117 (5) "Managed care organization" means an insurer, health care center,  
118 hospital service corporation, medical service corporation or other  
119 organization delivering, issuing for delivery, renewing, amending or  
120 continuing any individual or group health managed care plan in this  
121 state.

122 (6) "Managed care plan" means a product offered by a managed care  
123 organization that provides for the financing or delivery of health care  
124 services to persons enrolled in the plan through: (A) Arrangements with  
125 selected providers to furnish health care services; (B) explicit standards  
126 for the selection of participating providers; (C) financial incentives for  
127 enrollees to use the participating providers and procedures provided for  
128 by the plan; or (D) arrangements that share risks with providers,  
129 provided the organization offering a plan described under  
130 subparagraph (A), (B), (C) or (D) of this subdivision is licensed by the  
131 Insurance Department pursuant to chapter 698, 698a or 700 and the plan  
132 includes utilization review, as defined in section 38a-591a.

133 (7) "Preferred provider network" has the same meaning as provided  
134 in section 38a-479aa.

135 (8) "Provider" or "health care provider" means a person licensed to  
 136 provide health care services under chapters 370 to 373, inclusive, 375 to  
 137 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

138 (9) "Utilization review" has the same meaning as provided in section  
 139 38a-591a.

140 (10) "Utilization review company" has the same meaning as provided  
 141 in section 38a-591a.

142 Sec. 4. (NEW) (*Effective January 1, 2021*) For any contract delivered,  
 143 issued for delivery, renewed, amended or continued in this state on or  
 144 after January 1, 2021, each managed care organization shall, when  
 145 calculating an enrollee's liability for a coinsurance, copayment,  
 146 deductible or other out-of-pocket expense for a covered benefit, give  
 147 credit for any payment made by a third party for the amount of, or any  
 148 portion of the amount of, the coinsurance, copayment, deductible or  
 149 other out-of-pocket expense for the covered benefit.

150 Sec. 5. (NEW) (*Effective January 1, 2021*) On and after January 1, 2021,  
 151 each contract entered into between a health carrier, as defined in section  
 152 38a-591a of the general statutes, and a pharmacy benefits manager, as  
 153 defined in section 38a-479aaa of the general statutes, for the  
 154 administration of the pharmacy benefit portion of a health benefit plan  
 155 in this state on behalf of plan sponsors shall require that the pharmacy  
 156 benefits manager, when calculating an insured's or enrollee's liability for  
 157 a coinsurance, copayment, deductible or other out-of-pocket expense for  
 158 a covered prescription drug benefit, give credit for any payment made  
 159 by a third party for the amount of, or any portion of the amount of, the  
 160 coinsurance, copayment, deductible or other out-of-pocket expense for  
 161 the covered prescription drug benefit.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2021</i>	38a-1
Sec. 2	<i>January 1, 2021</i>	New section
Sec. 3	<i>January 1, 2021</i>	38a-478

Sec. 4	<i>January 1, 2021</i>	New section
Sec. 5	<i>January 1, 2021</i>	New section

***Statement of Purpose:***

To require certain health carriers and pharmacy benefits managers to give credit for payments made by third parties for the amount of, or any portion of the amount of, an insured's or enrollee's cost-sharing liability for a covered benefit.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*