SB 623

Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 623 (Senator Benson, *et al.*)
Finance

Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation

This bill requires insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers), when calculating the overall contribution to an out-of-pocket (OOP) maximum or a cost-sharing requirement, to include any payments made by, or on behalf of, the insured, subscriber, or member. **The bill takes effect January 1, 2021, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2021. MIA review of additional filings may necessitate contractual support in FY 2021 only. As the bill does not impact the calculation of the OOP maximum, there is no impact on the State Employee and Retiree Health and Welfare Benefits Program.

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Current Law: If a carrier negotiates and enters into a contract with providers to render health care services to insureds, subscribers, or members at alternative rates of payment, and coinsurance payments are based on a percentage of the fee, the carrier must calculate the amount of the coinsurance payment exclusively from the negotiated alternative rate. A

carrier may not charge or collect from an insured, subscriber, or member coinsurance that is greater than this amount.

Under the federal Patient Protection and Affordable Care Act, all nongrandfathered group health plans must ensure that any annual cost sharing imposed under the plan does not exceed specified limitations. For plan or policy years beginning in 2020, the maximum annual limitation on cost sharing is $8,150 for individual coverage and $16,300 for family coverage.

In the final *Notice of Benefit and Payment Parameters for 2020*, the U.S. Department of Health and Human Services (HHS) addressed how direct support offered by drug manufacturers to enrollees for specific prescription brand-name drugs (drug manufacturer coupons) count toward the annual limitation on cost sharing. The parameters stated that plans are permitted to exclude the value of drug manufacturer coupons from counting toward the annual limitation on cost sharing when a medically appropriate generic equivalent is available. Stakeholder feedback to HHS indicted that it was unclear if this required plans, in any other circumstances, to count such coupons toward the annual limitation on cost sharing. Thus, HHS deferred this interpretation regarding drug manufacturer coupons and announced plans to address the issue for the 2021 plan year.

Background: According to *Managed Care*, under a copay accumulator program, a health benefit or prescription drug plan does not allow the value of a drug manufacturer copay coupon to count against the beneficiary's deductible or OOP maximum. Once the coupon's value is exhausted, the beneficiary must pay the entire deductible before plan benefits begin. Copay maximizers are a variation on copay accumulators. Under a maximizer program, an insurer increases the copayment amount so that it approximates the coupon's monthly value. The total value of the coupon is applied evenly throughout the benefit year to cover a portion of drug costs, but it is not applied against the beneficiary's cost-sharing obligations. Health plans and pharmacy benefits managers use copay accumulators and maximizers to reduce their financial liability by drawing from the value of the coupon and the beneficiary cost-sharing amounts before providing prescription drug coverage. Opponents of these programs have raised concerns that beneficiaries may lack adequate notice of how they work and be surprised by having to pay high deductibles once their coupons are exhausted.

In 2019, Arizona, Virginia, and West Virginia passed similar legislation prohibiting health insurance plans from enacting copay accumulator policies that do not take into account third-party financial assistance toward a patient's OOP expenses.

Additional Information

Prior Introductions: None.

Designated Cross File: HB 1360 (Delegate P. Young, *et al.*) - Health and Government Operations.

Information Source(s): *Managed Care;* U.S. Department of Health and Human Services; Department of Budget and Management; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

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