SENATE BILL 595

J5 4lr1562
CF 4lr2511

By: **Senator Hershey**
Introduced and read first time: January 26, 2024
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements and Prohibitions

FOR the purpose of requiring administrators, carriers, and pharmacy benefits managers to include certain cost sharing amounts paid by or on behalf of an enrollee or a beneficiary when calculating the enrollee's or beneficiary's contribution to a cost sharing requirement; requiring administrators, carriers, and pharmacy benefits managers to include certain cost sharing amounts for certain high deductible health plans after an enrollee or a beneficiary satisfies a certain requirement; prohibiting administrators, carriers, and pharmacy benefits managers from directly or indirectly setting, altering, implementing, or conditioning the terms of certain coverage based on certain information; and generally relating to the calculation of cost sharing requirements.

BY adding to
Article – Insurance
Section 15–118.1 and 15–1611.3
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1601
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

Preamble

WHEREAS, Residents of Maryland frequently rely on State–regulated commercial health insurance carriers to secure access to the prescription medicines needed to protect their health; and

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

WHEREAS, Commercial health insurance designs increasingly require patients to bear significant out–of–pocket costs for their prescription medicines; and

WHEREAS, High out–of–pocket costs on prescription medicines impact the ability of patients to start new and necessary medicines and to stay adherent to their current prescriptions; and

WHEREAS, High or unpredictable cost sharing requirements are a main driver of elevated patient out–of–pocket costs and allow health insurance carriers to capture discounts and price concessions that are intended to benefit patients at the pharmacy counter; and

WHEREAS, Health insurance carriers unfairly increase cost sharing burdens on patients by refusing to count third–party assistance toward patients' cost sharing contributions; and

WHEREAS, The burdens of high or unpredictable cost sharing requirements are borne disproportionately by patients with chronic or debilitating conditions; and

WHEREAS, Restrictions are needed on the ability of health insurance carriers and their intermediaries to use unfair cost sharing designs to retain rebates and price concessions that instead should be directly passed on to patients as cost savings; and

WHEREAS, Patients need equitable and accessible health coverage that does not impose unfair cost sharing burdens on them; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–118.1.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "ADMINISTRATOR" HAS THE MEANING STATED IN § 8–301 OF THIS ARTICLE.

(3) "CARRIER" MEANS AN ENTITY SUBJECT TO THE JURISDICTION OF THE COMMISSIONER THAT CONTRACTS, OR OFFERS TO CONTRACT, TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES UNDER A HEALTH BENEFIT PLAN IN THE STATE.

(4) "COST SHARING" MEANS ANY COPAYMENT, COINSURANCE, DEDUCTIBLE, OR OTHER SIMILAR CHARGE REQUIRED OF AN ENROLLEE FOR A HEALTH CARE SERVICE COVERED BY A HEALTH BENEFIT PLAN, INCLUDING A PRESCRIPTION DRUG, AND PAID BY OR ON BEHALF OF THE ENROLLEE.

(5) "ENROLLEE" MEANS AN INDIVIDUAL ENTITLED TO PAYMENT FOR HEALTH CARE SERVICES FROM AN ADMINISTRATOR OR A CARRIER.

(6) "HEALTH BENEFIT PLAN" MEANS A POLICY, A CONTRACT, A CERTIFICATION, OR AN AGREEMENT OFFERED OR ISSUED BY AN ADMINISTRATOR OR A CARRIER TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

(7) "HEALTH CARE SERVICE" MEANS AN ITEM OR SERVICE PROVIDED TO AN INDIVIDUAL FOR THE PURPOSE OF PREVENTING, ALLEVIATING, CURING, OR HEALING HUMAN ILLNESS, INJURY, OR PHYSICAL DISABILITY.

(B) THE ANNUAL LIMITATION ON COST SHARING PROVIDED FOR UNDER 42 U.S.C. § 18022(C)(1) SHALL APPLY TO ALL HEALTH CARE SERVICES COVERED UNDER A HEALTH BENEFIT PLAN OFFERED OR ISSUED BY AN ADMINISTRATOR OR A CARRIER IN THE STATE.

(C) (1) SUBJECT TO PARAGRAPHS (2) AND (3) OF THIS SUBSECTION, WHEN CALCULATING AN ENROLLEE'S CONTRIBUTION TO AN APPLICABLE COST SHARING REQUIREMENT, AN ADMINISTRATOR OR A CARRIER SHALL INCLUDE COST SHARING AMOUNTS PAID BY THE ENROLLEE OR ON BEHALF OF THE ENROLLEE BY ANOTHER PERSON.

(2) IF THE APPLICATION OF THE REQUIREMENT UNDER PARAGRAPH (1) OF THIS SUBSECTION WOULD RESULT IN HEALTH SAVINGS ACCOUNT INELIGIBILITY UNDER § 223 OF THE INTERNAL REVENUE CODE, THE REQUIREMENT SHALL APPLY TO HEALTH SAVINGS ACCOUNT–QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS WITH RESPECT TO THE DEDUCTIBLE OF THE PLAN AFTER THE ENROLLEE SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE INTERNAL REVENUE CODE.

(3) FOR ITEMS OR SERVICES THAT ARE PREVENTIVE CARE IN ACCORDANCE WITH § 223(C)(2)(C) OF THE INTERNAL REVENUE CODE, THE REQUIREMENTS OF THIS SUBSECTION SHALL APPLY REGARDLESS OF WHETHER THE ENROLLEE SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE INTERNAL REVENUE CODE.

(D) AN ADMINISTRATOR OR A CARRIER MAY NOT DIRECTLY OR INDIRECTLY SET, ALTER, IMPLEMENT, OR CONDITION THE TERMS OF HEALTH BENEFIT PLAN COVERAGE, INCLUDING THE BENEFIT DESIGN, BASED IN WHOLE OR IN PART ON INFORMATION ABOUT THE AVAILABILITY OR AMOUNT OF FINANCIAL OR PRODUCT ASSISTANCE AVAILABLE FOR A PRESCRIPTION DRUG.

(E) THE COMMISSIONER MAY ADOPT REGULATIONS TO CARRY OUT THIS SECTION.

15–1601.

(a) In this subtitle the following words have the meanings indicated.

(b) "Agent" means a pharmacy, a pharmacist, a mail order pharmacy, or a nonresident pharmacy acting on behalf or at the direction of a pharmacy benefits manager.

(c) "Beneficiary" means an individual who receives prescription drug coverage or benefits from a purchaser.

(d) (1) "Carrier" means the State Employee and Retiree Health and Welfare Benefits Program, an insurer, a nonprofit health service plan, **[**or**]** a health maintenance organization**, OR ANY OTHER ENTITY SUBJECT TO THE JURISDICTION OF THE COMMISSIONER** that:

(i) provides prescription drug coverage or benefits in the State; and

(ii) enters into an agreement with a pharmacy benefits manager for the provision of pharmacy benefits management services.

(2) "Carrier" does not include a person that provides prescription drug coverage or benefits through plans subject to ERISA and does not provide prescription drug coverage or benefits through insurance, unless the person is a multiple employer welfare arrangement as defined in § 514(b)(6)(a)(ii) of ERISA.

(e) "Compensation program" means a program, policy, or process through which sources and pricing information are used by a pharmacy benefits manager to determine the terms of payment as stated in a participating pharmacy contract.

(f) "Contracted pharmacy" means a pharmacy that participates in the network of a pharmacy benefits manager through a contract with:

(1) the pharmacy benefits manager; or

(2) a pharmacy services administration organization or a group purchasing organization.

(G) "COST SHARING" MEANS ANY COPAYMENT, COINSURANCE, DEDUCTIBLE, OR OTHER SIMILAR CHARGE REQUIRED OF A BENEFICIARY FOR A HEALTH CARE SERVICE COVERED BY A HEALTH BENEFIT PLAN, INCLUDING A PRESCRIPTION DRUG, AND PAID BY OR ON BEHALF OF THE BENEFICIARY.

[(g)**] (H)** "ERISA" has the meaning stated in § 8–301 of this article.

[(h)**] (I)** "Formulary" means a list of prescription drugs used by a purchaser.

(J) "HEALTH BENEFIT PLAN" MEANS A POLICY, A CONTRACT, A CERTIFICATION, OR AN AGREEMENT OFFERED OR ISSUED BY AN ADMINISTRATOR OR A CARRIER TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY PORTION OF THE COST OF HEALTH CARE SERVICES.

(K) "HEALTH CARE SERVICE" MEANS AN ITEM OR SERVICE PROVIDED TO AN INDIVIDUAL FOR THE PURPOSE OF PREVENTING, ALLEVIATING, CURING, OR HEALING HUMAN ILLNESS, INJURY, OR PHYSICAL DISABILITY.

[(i)**] (L)** (1) "Manufacturer payments" means any compensation or remuneration a pharmacy benefits manager receives from or on behalf of a pharmaceutical manufacturer.

(2) "Manufacturer payments" includes:

(i) payments received in accordance with agreements with pharmaceutical manufacturers for formulary placement and, if applicable, drug utilization;

(ii) rebates, regardless of how categorized;

(iii) market share incentives;

(iv) commissions;

(v) fees under products and services agreements;

(vi) any fees received for the sale of utilization data to a pharmaceutical manufacturer; and

(vii) administrative or management fees.

(3) "Manufacturer payments" does not include purchase discounts based on invoiced purchase terms.

[(j)**] (M)** "Nonprofit health maintenance organization" has the meaning stated in § 6–121(a) of this article.

[(k)**] (N)** "Nonresident pharmacy" has the meaning stated in § 12–403 of the Health Occupations Article.

[(l)**] (O)** "Participating pharmacy contract" means a contract filed with the Commissioner in accordance with § 15–1628(b) of this subtitle.

[(m)**] (P)** "Pharmacist" has the meaning stated in § 12–101 of the Health Occupations Article.

[(n)**] (Q)** "Pharmacy" has the meaning stated in § 12–101 of the Health Occupations Article.

[(o)**] (R)** "Pharmacy and therapeutics committee" means a committee established by a pharmacy benefits manager to:

(1) objectively appraise and evaluate prescription drugs; and

(2) make recommendations to a purchaser regarding the selection of drugs for the purchaser's formulary.

[(p)**] (S)** (1) "Pharmacy benefits management services" means:

(i) the **[**procurement of prescription drugs at a negotiated rate for dispensation within the State to beneficiaries**] NEGOTIATION OF THE PRICE OF PRESCRIPTION DRUGS, INCLUDING THE NEGOTIATING AND CONTRACTING FOR DIRECT AND INDIRECT REBATES, DISCOUNTS, OR OTHER PRICE CONCESSIONS**;

(ii) the administration or management of prescription drug coverage provided by a purchaser for beneficiaries; **[**and**]**

(iii) any of the following services provided with regard to the administration of prescription drug coverage:

1. mail service pharmacy;

2. claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;

3. clinical formulary development and management services;

4. rebate contracting and administration;

5. patient compliance, therapeutic intervention, and generic substitution programs; **[**or**]**

6. disease management programs**;**

7. DRUG UTILIZATION REVIEW; OR

8. ADJUDICATION OF APPEALS OR GRIEVANCES RELATED TO A PRESCRIPTION DRUG BENEFIT;

(IV) THE PERFORMANCE OF ADMINISTRATIVE, MANAGERIAL, CLINICAL, PRICING, FINANCIAL, REIMBURSEMENT, DATA ADMINISTRATION OR REPORTING, OR BILLING SERVICES; OR

(V) OTHER SERVICES DEFINED BY THE COMMISSIONER IN REGULATION.

(2) "Pharmacy benefits management services" does not include any service provided by a nonprofit health maintenance organization that operates as a group model, provided that the service:

(i) is provided solely to a member of the nonprofit health maintenance organization; and

(ii) is furnished through the internal pharmacy operations of the nonprofit health maintenance organization.

[(q)**] (T)** "Pharmacy benefits manager" means**:**

(1) a person that **[**performs**], IN ACCORDANCE WITH A WRITTEN AGREEMENT WITH A PURCHASER, EITHER DIRECTLY OR INDIRECTLY, PROVIDES ONE OR MORE** pharmacy benefits management services**; OR**

(2) AN AGENT OR OTHER PROXY OR REPRESENTATIVE, CONTRACTOR, INTERMEDIARY, AFFILIATE, SUBSIDIARY, OR RELATED ENTITY OF A PERSON THAT FACILITATES, PROVIDES, DIRECTS, OR OVERSEES THE PROVISION OF PHARMACY BENEFITS MANAGEMENT SERVICES.

[(r)**] (U)** "Proprietary information" means:

(1) a trade secret;

(2) confidential commercial information; or

(3) confidential financial information.

[(s)**] (V)** "Purchaser" means a person that offers a plan or program in the State, including the State Employee and Retiree Health and Welfare Benefits Program, that:

(1) provides prescription drug coverage or benefits in the State; and

(2) enters into an agreement with a pharmacy benefits manager for the provision of pharmacy benefits management services.

[(t)**] (W)** "Rebate sharing contract" means a contract between a pharmacy benefits manager and a purchaser under which the pharmacy benefits manager agrees to share manufacturer payments with the purchaser.

[(u)**] (X)** (1) "Therapeutic interchange" means any change from one prescription drug to another.

(2) "Therapeutic interchange" does not include:

(i) a change initiated pursuant to a drug utilization review;

(ii) a change initiated for patient safety reasons;

(iii) a change required due to market unavailability of the currently prescribed drug;

(iv) a change from a brand name drug to a generic drug in accordance with § 12–504 of the Health Occupations Article; or

(v) a change required for coverage reasons because the originally prescribed drug is not covered by the beneficiary's formulary or plan.

[(v)**] (Y)** "Therapeutic interchange solicitation" means any communication by a pharmacy benefits manager for the purpose of requesting a therapeutic interchange.

[(w)**] (Z)** "Trade secret" has the meaning stated in § 11–1201 of the Commercial Law Article.

15–1611.3.

(A) THIS SECTION APPLIES ONLY TO A PHARMACY BENEFITS MANAGER THAT PROVIDES PHARMACY BENEFITS MANAGEMENT SERVICES ON BEHALF OF A CARRIER.

(B) (1) SUBJECT TO PARAGRAPHS (2) AND (3) OF THIS SUBSECTION, WHEN CALCULATING A BENEFICIARY'S CONTRIBUTION TO AN APPLICABLE COST SHARING REQUIREMENT, A PHARMACY BENEFITS MANAGER SHALL INCLUDE COST SHARING AMOUNTS PAID BY THE BENEFICIARY ON BEHALF OF THE BENEFICIARY BY ANOTHER PERSON.

(2) IF THE APPLICATION OF THE REQUIREMENT UNDER PARAGRAPH (1) OF THIS SUBSECTION WOULD RESULT IN HEALTH SAVINGS ACCOUNT INELIGIBILITY UNDER § 223 OF THE INTERNAL REVENUE CODE, THE REQUIREMENT SHALL APPLY TO HEALTH SAVINGS ACCOUNT–QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS WITH RESPECT TO THE DEDUCTIBLE OF THE PLAN AFTER THE BENEFICIARY SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE INTERNAL REVENUE CODE.

(3) FOR ITEMS OR SERVICES THAT ARE PREVENTIVE CARE IN ACCORDANCE WITH § 223(C)(2)(C) OF THE INTERNAL REVENUE CODE, THE REQUIREMENTS OF THIS SUBSECTION SHALL APPLY REGARDLESS OF WHETHER THE BENEFICIARY SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE INTERNAL REVENUE CODE.

(C) A PHARMACY BENEFITS MANAGER MAY NOT DIRECTLY OR INDIRECTLY SET, ALTER, IMPLEMENT, OR CONDITION THE TERMS OF HEALTH BENEFIT PLAN COVERAGE, INCLUDING THE BENEFIT DESIGN, BASED IN WHOLE OR IN PART ON INFORMATION ABOUT THE AVAILABILITY OR AMOUNT OF FINANCIAL OR PRODUCT ASSISTANCE AVAILABLE FOR A PRESCRIPTION DRUG.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health plans issued, delivered, or renewed in the State on or after January 1, 2025.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2025.