SB 595

Department of Legislative Services

Maryland General Assembly
2024 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 595 (Senator Hershey)

Finance Health and Government Operations

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

This bill requires an administrator, a carrier, and certain pharmacy benefits managers (PBMs), when calculating an enrollee's or beneficiary's contribution to an applicable cost sharing requirement, to include any payments made by, or on behalf of, the enrollee or beneficiary, except as specified. An administrator, carrier, or PBM may not directly or indirectly set, alter, implement, or condition the terms of health benefit plan coverage based on information about the availability or amount of financial or product assistance available for a prescription drug or biological product. A specified annual limitation on cost sharing must apply to all health care services covered under a health benefit plan offered or issued by an administrator or a carrier in the State. The bill also alters the definitions of "pharmacy benefits manager" and "pharmacy benefits management services." **The bill takes effect January 1, 2025, and applies to all policies, contracts, and health plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Special fund revenues increase for the Maryland Insurance Administration (MIA) beginning in FY 2025, likely by a minimal amount, from additional PBM registrations, as discussed below. Additional minimal increase in MIA special fund revenues in FY 2025 only from the $125 rate and form filing fee. Any additional MIA workload is assumed to be absorbable within existing budgeted resources. No impact on the State Employee and Retiree Health and Welfare Benefits Program, as discussed below.

Local Effect: To the extent the bill's requirements increase the cost of health insurance, expenditures for local governments that purchase fully insured medical plans may increase. Revenues are not affected.

Small Business Effect: Minimal.

Analysis

Bill Summary:

Definitions

"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.

"Health benefit plan" means a policy, contract, certification, or agreement offered or issued by an administrator or a carrier to provide, deliver, arrange for, pay for, or reimburse any portion of the costs of health care services.

"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.

Cost Sharing Requirements – Administrators and Carriers

"Administrator" means a person that, to the extent that the person is acting for an insurer or plan sponsor, has control over or custody of premiums, contributions, or any other money for any period of time or discretionary authority over the adjustment, payment, or settlement of benefit claims under a plan or over the investment of a plan's assets. "Administrator" excludes specified persons, including a person that administers only plans that are subject to the federal Employee Retirement Income Security Act and that do not provide benefits through insurance, unless any of the plans administered is a multiple employer welfare arrangement.

"Carrier" means an entity subject to the jurisdiction of the Commissioner that contracts, or offers to contract, provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services in the State.

The annual limitation on cost sharing for all nongrandfathered health plans under the federal Patient Protection and Affordable Care Act (ACA) must apply to all health care services covered under a health benefit plan offered or issued by an administrator or a carrier in the State. (For 2024, the maximum annual limitation on cost sharing is $9,450 for individual coverage and $18,900 for family coverage).

When calculating an enrollee's or beneficiary's contribution to an applicable cost sharing requirement, an administrator or carrier must include any payments made by, or on behalf of, the enrollee or beneficiary. For a covered prescription drug or biological product, an administrator or carrier must only apply this requirement if the prescription drug or

biological product does not have an AB-rated generic equivalent or an interchangeable biological product preferred under the health benefit plan's formulary or, if there is such an alternative, the enrollee has obtained access to a brand drug through a prior authorization, step therapy protocol, or exception or appeal process of the administrator or carrier.

If an enrollee is covered under a health savings account-eligible high-deductible health plan (HDHP), an administrator or carrier must include any payments made by, or on behalf of, an enrollee when calculating an enrollee's contribution to a cost sharing requirement after the enrollee satisfies the HDHP's minimum deductible requirement. For preventive care items and services, an administrator or carrier must apply this requirement regardless of whether the enrollee has satisfied the HDHP's minimum deductible.

An administrator or 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 or biological product.

The Commissioner may adopt regulations to implement these provisions.

Pharmacy Benefits Managers and Pharmacy Benefits Management Services

"Carrier" means the State Employee and Retiree Health and Welfare Benefits Program, an insurer, a nonprofit health service plan, a health maintenance organization, or any other entity subject to the jurisdiction of the Commissioner that provides prescription drug coverage or benefits in the State and enters into an agreement with a PBM for the provision of pharmacy benefits management services.

The bill expands the definition of "pharmacy benefits manager" to mean (1) a person that, 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.

The bill alters the definition of "pharmacy benefits management services" to include the negotiation of the price of prescription drugs, including the negotiating and contracting for direct and indirect rebates, discounts, or other price concessions (rather than the procurement of prescription drugs at a negotiated rate for dispensation within the State to beneficiaries). The definition is also expanded to include (1) drug utilization review and adjudication of appeals or grievances related to a prescription drug benefit provided with regard to the administration of prescription drug coverage; (2) the performance of

administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting, or billing services; or (3) other services defined by the Commissioner in regulation.

Cost Sharing Requirements – Pharmacy Benefits Managers

When calculating a beneficiary's contribution to an applicable cost sharing requirement, a PBM that provides pharmacy benefits management services on behalf of a carrier must include any payments made by, or on behalf of, the beneficiary. For a covered prescription drug or biological product, a PBM must only apply this requirement if the prescription drug or biological product does not have an AB-rated generic equivalent or an interchangeable biological product preferred under the health benefit plan's formulary or, if there is such an alternative, the beneficiary has obtained access to a brand drug through a prior authorization, step therapy protocol, or exception or appeal process of the administrator or carrier.

If a beneficiary is covered under a health savings account-eligible HDHP, a PBM must include any payments made by, or on behalf of, a beneficiary when calculating a beneficiary's contribution to a cost sharing requirement after the beneficiary satisfies the HDHP's minimum deductible requirement. For preventive care items and services, a PBM must apply this requirement regardless of whether the beneficiary has satisfied the HDHP's minimum deductible.

A PBM 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 or biological product.

Current Law:

Cost Sharing – Patient Protection and Affordable Care Act

Under the ACA, 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 2024, the maximum annual limitation on cost sharing is $9,450 for individual coverage and $18,900 for family coverage. The out-of-pocket maximum is set annually by the U.S. Department of Health and Human Services based on a formula that calculates how much the average premium for employer-sponsored health insurance in the preceding year exceeds the average 2014 premium for employer-sponsored health insurance.

Pharmacy Benefits Managers

A PBM is a business that administers and manages prescription drug benefit plans. A PBM must register with MIA prior to providing pharmacy benefits management services. An applicant for registration must (1) file an application on the form that MIA provides and (2) pay a registration fee set by the Commissioner.

A PBM that provides pharmacy benefits management services on behalf of a carrier may not require that a beneficiary use a specific pharmacy or entity to fill a prescription if the PBM (or a corporate affiliate) has an ownership interest in the pharmacy or entity or vice versa. A PBM may require a beneficiary to use a specific pharmacy or entity for a specialty drug.

A PBM that provides pharmacy benefits management services on behalf of a carrier may not reimburse a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less than the PBM reimburses itself or an affiliate for providing the same product or service. This prohibition does not apply to reimbursement for specialty drugs, mail order drugs, or to a chain pharmacy with more than 15 stores or a pharmacist who is an employee of the chain pharmacy.

State Revenues: According to MIA, at the end of calendar 2022, there were 56 PBMs in Maryland. Each PBM must pay an initial registration fee and a renewal fee every two years thereafter. The initial and renewal fee is $5,000.

Under the bill, special fund revenues for MIA increase by an indeterminate but likely minimal amount beginning in fiscal 2025 due to additional entities having to register as PBMs. The Department of Legislative Services advises that the magnitude of the revenue increase cannot be estimated at this time, as it is contingent on the number of new entities that are required to register as PBMs. *For illustrative purposes only*, if 10 additional entities apply to register with MIA as PBMs, special fund revenues increase by $50,000 in fiscal 2025, and by $50,000 in fiscal 2027 (and every two years thereafter).

State Expenditures: The Department of Budget and Management (DBM) advises that the State Employee and Retiree Health and Welfare Benefits Program does not employ the cost sharing methodologies that the bill restricts; thus, the bill has no impact on the program at this time. However, DBM notes that the bill limits the program's future flexibility to implement cost-saving measures related to cost sharing for health services and prescription drugs.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years; however, legislation with similar provisions has been proposed. For example, see HB 167 and SB 290 of 2021.

Designated Cross File: HB 879 (Delegate S. Johnson, *et al.*) - Health and Government Operations.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Insurance Administration; Department of Legislative Services

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