# HOUSE BILL 274

C3 0lr0982

By: **Delegate King**
Introduced and read first time: January 25, 2010
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

**Health Insurance – Benefit Cards – Copayments**

FOR the purpose of requiring certain insurers, nonprofit health service plans, health maintenance organizations, managed care organizations, and third party administrators that provide certain coverage for prescription drugs to include required copayments for prescription drug benefits on a health insurance benefit card, prescription drug card, or other technology; requiring certain insurers, nonprofit health service plans, health maintenance organizations, managed care organizations, and third party administrators to provide to their insureds, subscribers, or enrollees a health insurance benefit card that includes required copayments for certain medical visits; requiring a new health insurance benefit card to be provided under certain circumstances; making certain provisions of law applicable to health maintenance organizations; and generally relating to health insurance and prescription drug benefit card requirements.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–130
Annotated Code of Maryland
(2006 Replacement Volume and 2009 Supplement)

BY adding to
Article – Insurance
Section 15–130.1
Annotated Code of Maryland
(2006 Replacement Volume and 2009 Supplement)

BY adding to
Article – Health – General
Section 19–706(cccc)

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

Annotated Code of Maryland
(2009 Replacement Volume)

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

**Article – Insurance**

15–130.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs on an outpatient basis under health insurance policies or contracts that are issued or delivered in the State;

(ii) health maintenance organizations that provide coverage for prescription drugs on an outpatient basis under contracts that are issued or delivered in the State;

(iii) managed care organizations, as defined in § 15–101 of the Health – General Article, that provide coverage for prescription drugs on an outpatient basis under contracts that are issued or delivered in the State; and

(iv) to the extent consistent with State and federal law, third party administrators.

(2) This section does not apply to:

(i) short–term travel or accident–only policies;

(ii) short–term nonrenewable policies of not more than 6 months duration; or

(iii) any health maintenance organization that operates or maintains its own pharmacies and dispenses, on an annual basis, over 95% of prescription drugs on an outpatient basis to its enrollees at its own pharmacies.

(b) Each entity subject to this section shall provide to its insureds, subscribers, or enrollees a health insurance benefit card, prescription benefit card, or other technology that:

(1) **(I)** complies with the standards set forth in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect at the time of issuance of the card or other technology; or

**[**(2)**]** **(II)** includes, at a minimum, the following data elements:

**[**(i)**]** **1.** the name or identifying trademark of the entity subject to this section or, if another entity administers the prescription benefit, the name or identifying trademark of the benefit administrator;

**[**(ii)**]** **2.** the name and identification number of the insured, subscriber, or enrollee;

**[**(iii)**]** **3.** the telephone number that providers may call for pharmacy benefit assistance; and

**[**(iv)**]** **4.** all electronic transaction routing information and other numbers required by the entity subject to this section or benefit administrator to process a prescription claim electronically**; AND**

**(2) INCLUDES REQUIRED COPAYMENTS FOR PRESCRIPTION DRUG BENEFITS**.

(c) If an entity subject to this section contracts with or otherwise arranges for the prescription benefit to be administered by another subsidiary or entity, including a pharmacy benefit manager, the entity subject to this section shall require the benefit administrator to comply with this section.

(d) (1) The health insurance benefit card, prescription benefit card, or other technology shall be issued to each insured, subscriber, or enrollee by an entity subject to this section.

(2) If a change occurs in any of the data elements required under subsection (b)(2) of this section, an entity subject to this section shall:

(i) reissue a health insurance benefit card, prescription drug benefit card, or other technology; or

(ii) provide the insured, subscriber, or enrollee with the corrective information necessary to electronically process a prescription claim.

(e) An entity subject to this section may comply with this section by issuing to each insured, subscriber, or enrollee a health insurance benefit card that contains data elements related to both prescription and nonprescription health insurance benefits.

(f) The Department of Health and Mental Hygiene shall adopt regulations to enable managed care organizations to comply with:

(1) the requirements of this section; and

(2) any unique requirements of the HealthChoice Program that relate to the electronic processing of claims.

**15–130.1.**

**(A) THIS SECTION APPLIES TO:**

**(1) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS ON AN EXPENSE–INCURRED BASIS UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE;**

**(2) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS UNDER CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE;**

**(3) MANAGED CARE ORGANIZATIONS, AS DEFINED IN § 15–101 OF THE HEALTH – GENERAL ARTICLE; AND**

**(4) TO THE EXTENT CONSISTENT WITH STATE AND FEDERAL LAW, THIRD PARTY ADMINISTRATORS.**

**(B) EACH ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE TO ITS INSUREDS, SUBSCRIBERS, OR ENROLLEES A HEALTH INSURANCE BENEFIT CARD THAT INCLUDES REQUIRED COPAYMENTS FOR PRIMARY CARE, SPECIALTY CARE, AND EMERGENCY DEPARTMENT VISITS.**

**(C) IF A CHANGE OCCURS IN A REQUIRED COPAYMENT, AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE A NEW HEALTH INSURANCE BENEFIT CARD TO ITS INSUREDS, SUBSCRIBERS, OR ENROLLEES.**

**Article – Health – General**

19–706.

**(CCCC) THE PROVISIONS OF § 15–130.1 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2010.