Department of Legislative Services

Maryland General Assembly
2010 Session

FISCAL AND POLICY NOTE

Senate Bill 663 (Senator Klausmeier, *et al.*)
Finance

Health Insurance - Prescription Drugs - Cost-Sharing Obligations

This bill prohibits unfair discrimination between individuals of the same class in the amount of the cost-sharing obligation for a prescription drug. Specifically, insurers, nonprofit health service plans, and health maintenance organizations (carriers) that provide prescription drug coverage and determine cost-sharing obligations by category of prescription drugs may not impose a cost-sharing obligation that exceeds the dollar amount for a prescription drug in the category of nonpreferred brand-name drug or its equivalent.

The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2010.

Fiscal Summary

State Effect: None. The bill does not affect the State Employee and Retiree Health and Welfare Benefits Program because the benefit offered by the program's prescription drug contract only has three tiers.

Local Effect: Expenditures for some local governments may increase beginning in fiscal 2011.

Small Business Effect: None. The bill does not apply to the small group market.

Analysis

Current Law: None applicable.

Background: Most prescription drug coverage includes a three-tiered copayment arrangement under which enrollees pay a specific dollar amount for each prescription in a given tier of drugs (*i.e.*, generic, preferred brand-name, and nonpreferred brand-name). Recently, some insurance companies have implemented a "fourth tier" for specialty drugs, which generally includes prescription medicines used to treat complex, chronic conditions and may require special administration, handling, or care management. Fourth tiers are intended to address high drug costs by encouraging enrollees to consider less expensive options and to share a greater proportion of the cost of specialty drugs, some of which can cost as much as $100,000 per year, to keep overall premiums down. Nationally, as many as 10% of commercial health insurance plans have established fourth tiers. Rather than using a fixed copayment obligation as is typical with other tiers, insurers often charge consumers 20% to 33% of the drug price for fourth-tier drugs. This disparity in cost sharing can impose a significant burden on individuals with health conditions such as multiple sclerosis, cancer, hemophilia, hepatitis C, or rheumatoid arthritis who require specialty drugs for which no generic or less expensive alternative exists.

This bill is similar to legislation currently pending in the New York State Assembly.

Health Insurance Mandates as They Relate to State and Local Governments and the Small Group Market

Employers have two major options when providing health insurance benefits. They can purchase a fully insured plan from an insurance company or they can self-insure by assuming risk and paying all claims for services themselves, usually through a third-party administrator. The federal Employee Retirement Income Security Act (ERISA) preempts states' ability to require private employers to offer insurance coverage and exempts the coverage offered by self-insured entities from state insurance regulation. Therefore, the health insurance requirements under Title 15, Subtitles 4, 7, and 8 of the Insurance Article apply only to fully insured health benefit plans.

Government entities that self-fund their health benefit plans are *not exempt* under ERISA from state regulation and health insurance mandates. In Maryland, these entities have instead been exempt from these requirements based on the State definition of "insurance business." An insurance business includes the transaction of all matters pertaining to an insurance contract, either before or after it takes effect and all matters arising from an insurance contract or a claim under it. Insurance business *does not* include pooling by public entities for self-insurance of casualty, property, or health risks.

In 2008, the Maryland Association of Counties and the Maryland Association of Boards of Education conducted an informal survey of counties and county school boards about

their insurance plans, to which 22 counties and 19 school boards responded. Of the 22 responding counties, 13 were self-insured, 4 were fully insured, and 5 offered both self-insured and fully insured options. Of the 19 responding county school boards, 14 were self-insured, 1 was fully insured, and 4 offered both self-insured and fully insured options. The fully insured plans offered by counties and county school boards are subject to State insurance laws.

Maryland's small group market Comprehensive Standard Health Benefit Plan (CSHBP) is not subject to mandated benefits applicable to the large group market. Rather, the Maryland Health Care Commission reviews CSHBP on an annual basis and considers making benefit or cost sharing changes at that time.

Local Expenditures: Local government expenditures (for those that purchase fully insured plans from an insurance company) could increase for some local governments beginning in fiscal 2011 if insurers choose to pass additional costs along to all enrollees for more expensive drugs in lieu of charging higher copayments for more expensive drugs.

Additional Information

Prior Introductions: None.

Cross File: HB 478 (Delegate Pena-Melnyk, *et al.*) - Health and Government Operations.

Information Source(s): CareFirst Blue Cross/Blue Shield, Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, *The New England Journal of Medicine*, *The New York Times*, New York State Assembly, Department of Legislative Services

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