Department of Legislative Services

Maryland General Assembly
2011 Session

FISCAL AND POLICY NOTE

House Bill 251 (Delegates Nathan-Pulliam and Pena-Melnyk)
Health and Government Operations

Health Insurance - Prescription Drugs - Cost-Sharing Obligations

This bill prohibits insurers, nonprofit health service plans, and health maintenance organizations from imposing a "cost-sharing obligation" that exceeds $100 for one month's supply of a covered prescription drug. A carrier may increase the $100 cap on the cost-sharing obligation once annually to reflect inflation. The cap does not apply to a month's supply of a brand-name drug for which a generic equivalent is available.

The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2011.

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 2012. Review of filings can be handled with existing budgeted MIA resources. No impact on the State Employee and Retiree Health and Welfare Benefits Program (State plan) compared with current law. However, the Governor's FY 2012 budget proposes a new retiree prescription drug program, contingent on the Budget Reconciliation and Financing Act of 2011. The bill reduces the savings the Administration can expect to generate under the new program by an estimated $14.6 million (all funds) in FY 2013.

Local Effect: Expenditures for some local governments may increase beginning in FY 2012.

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

Analysis

Bill Summary: "Cost-sharing obligation" means a copayment or coinsurance requirement but does not include any deductible. Any annual inflationary adjustment of the cap on the cost-sharing obligation cannot exceed the percentage change in the medical component of the March Consumer Price Index for All Urban Consumers, medical care component, Washington-Baltimore, from the U.S. Department of Labor, Bureau of Labor Statistics.

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 begun offering drug plans with coinsurance under which a member pays a percentage of the drug cost rather than a fixed-dollar copayment. Other carriers have implemented a "fourth tier" for specialty drugs, which generally includes prescription medicines used to treat complex, chronic conditions. Nationally, as many as 10% of commercial health insurance plans have fourth tiers for prescription drugs. In 2010, New York State enacted legislation to prohibit specialty (or fourth) tiers in prescription drug formularies.

According to the Kaiser Family Foundation/Health Research & Education Trust's 2010 Annual Employee Health Benefits Survey, 89% of covered workers had a tiered cost-sharing formula for prescription drugs. For covered workers with three or more tiers, the average copayments were $11/$28/$49, while the average coinsurance amounts were 17%/25%/38%. The average copayment for a fourth tier drug was $89, and the average coinsurance was 36%.

Prescription drug coverage under the State plan currently uses a three-tier copayment structure with an annual out-of-pocket cap per individual/family. In fiscal 2011, copayments are $5/$15/$25 with a $700 out-of-pocket cap. For coverage in fiscal 2012, copayments for active State employees will increase to $10/$25/$40 with out-of-pocket caps of $1,000 per individual and $1,500 per family.

The Governor's proposed fiscal 2012 budget assumes $46 million in total savings ($22 million in general funds) based on establishment of a separate retiree prescription drug plan. This action is contingent on language in the Budget Reconciliation and Financing Act of 2011. According to the Department of Budget and Management, retiree prescription coverage would mirror the basic Medicare Part D plan. Retirees would pay the first $310 in prescription costs annually. After meeting the $310 annual deductible, retirees would pay 25% of prescription costs up to $4,550 in total out-of-pocket expenses.

After meeting the out-of-pocket maximum, the State plan would cover 100% of prescription drug expenses for the remainder of the plan year.

The Maryland Health Insurance Plan (MHIP) currently charges a $125 copayment for a month's supply of fourth tier prescription drugs. However, this bill does not apply to MHIP.

State Fiscal Effect: Compared with current law, the bill has no impact on the State plan, which currently does not impose any cost-sharing obligation above $100 per prescription per month. However, the bill will limit the savings expected under the new retiree prescription drug program envisioned by the Administration. Relative to the Administration's plan, retiree prescription drug expenditures increase by an estimated $14.6 million in fiscal 2013 due to an increase in the State plan's share of costs. Expected future year savings would likewise be reduced.

Although not required to follow health insurance mandates or other requirements, the State plan generally does. Thus, it is assumed that the State plan will implement the requirements of the bill. As the State plan contract runs on a fiscal-year basis, the cap on cost-sharing obligation required would not be included until the fiscal 2013 plan year.

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 2012 if insurers choose to pass additional costs along to all enrollees in lieu of being able to charge higher copayments for more expensive drugs.

Additional Comments: Based on informal discussions with medical and pharmacy directors of most major carriers in Maryland, the Maryland Health Care Commission indicates that the vast majority of plans in the regulated Maryland markets either do not use a fourth tier for prescription drugs or already have a cost-sharing cap in place. Furthermore, several carriers noted that many employers that offer self-insured plans that are exempt from State regulation also place a cost-sharing cap on their pharmacy benefit to protect employees against high cost-sharing. Because these capped designs already exist in the marketplace, the administrative burdens of the cap are likely to be modest for most plans.

Additional Information

Prior Introductions: None.

Cross File: SB 709 (Senator Klausmeier, *et al.*) – Finance.

Information Source(s): *2010 Annual Employer Health Benefits Survey,* Kaiser Family Foundation/Health Research & Educational Trust, September 2010; Baltimore, Garrett, Howard, and Montgomery counties; Department of Budget and Management; Maryland Health Insurance Plan; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

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