SENATE BILL 595

J5 4lr1562
CF HB 879

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

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: February 27, 2024

CHAPTER ______

1 AN ACT concerning

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

4 FOR the purpose of requiring administrators, carriers, and pharmacy benefits managers to
5 include certain cost sharing amounts paid by or on behalf of an enrollee or a
6 beneficiary when calculating the enrollee's or beneficiary's contribution to a cost
7 sharing requirement <u>for certain health care services</u>; requiring administrators,
8 carriers, and pharmacy benefits managers to include certain cost sharing amounts
9 for certain high deductible health plans after an enrollee or a beneficiary satisfies a
10 certain requirement; prohibiting administrators, carriers, and pharmacy benefits
11 managers from directly or indirectly setting, altering, implementing, or conditioning
12 the terms of certain coverage based on certain information; and generally relating to
13 the calculation of cost sharing requirements.

14 BY adding to
15 Article – Insurance
16 Section 15–118.1 and 15–1611.3
17 Annotated Code of Maryland
18 (2017 Replacement Volume and 2023 Supplement)

19 BY repealing and reenacting, with amendments,
20 Article – Insurance
21 Section 15–1601
22 Annotated Code of Maryland
23 (2017 Replacement Volume and 2023 Supplement)

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.
<u>Underlining</u> indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

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

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.

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

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

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

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

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

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

22 (C) (1) FOR A PRESCRIPTION DRUG OR BIOLOGICAL PRODUCT COVERED
23 BY A HEALTH BENEFIT PLAN, THIS SUBSECTION APPLIES ONLY WITH RESPECT TO A
24 PRESCRIPTION DRUG OR BIOLOGICAL PRODUCT:

25 (I) THAT DOES NOT HAVE AN AB–RATED GENERIC EQUIVALENT
26 OR AN INTERCHANGEABLE BIOLOGICAL PRODUCT PREFERRED UNDER THE
27 FORMULARY OF THE HEALTH BENEFIT PLAN; OR

28 (II) 1. THAT HAS AN AB–RATED GENERIC EQUIVALENT OR
29 AN INTERCHANGEABLE BIOLOGICAL PRODUCT PREFERRED UNDER THE
30 FORMULARY OF THE HEALTH BENEFIT PLAN; AND

31 2. TO WHICH THE ENROLLEE HAS OBTAINED ACCESS
32 THROUGH A PRIOR AUTHORIZATION, STEP THERAPY PROTOCOL, OR EXCEPTION OR
33 APPEAL PROCESS OF THE ADMINISTRATOR OR CARRIER.

(2) SUBJECT TO PARAGRAPHS ~~(2) AND (3)~~ (3) AND (4) 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)~~ (3) IF THE APPLICATION OF THE REQUIREMENT UNDER PARAGRAPH ~~(1)~~ (2) 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)~~ (4) 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 OR BIOLOGICAL PRODUCT**.**

(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:

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

3 (ii) rebates, regardless of how categorized;

4 (iii) market share incentives;

5 (iv) commissions;

6 (v) fees under products and services agreements;

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

9 (vii) administrative or management fees.

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

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

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

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

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

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

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

24 (1) objectively appraise and evaluate prescription drugs; and

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

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

28 (i) the **[**procurement of prescription drugs at a negotiated rate for
29 dispensation within the State to beneficiaries**] NEGOTIATION OF THE PRICE OF**

1 **PRESCRIPTION DRUGS, INCLUDING THE NEGOTIATING AND CONTRACTING FOR**
2 **DIRECT AND INDIRECT REBATES, DISCOUNTS, OR OTHER PRICE CONCESSIONS**;

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

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

7 1. mail service pharmacy;

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

10 3. clinical formulary development and management services;

11 4. rebate contracting and administration;

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

14 6. disease management programs**;**

15 **7. DRUG UTILIZATION REVIEW; OR**

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

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

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

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

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

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

30 **[**(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) FOR A PRESCRIPTION DRUG OR BIOLOGICAL PRODUCT COVERED BY A HEALTH BENEFIT PLAN, THIS SUBSECTION APPLIES ONLY WITH RESPECT TO A PRESCRIPTION DRUG OR BIOLOGICAL PRODUCT:

(I) THAT DOES NOT HAVE AN AB–RATED GENERIC EQUIVALENT OR AN INTERCHANGEABLE BIOLOGICAL PRODUCT PREFERRED UNDER THE FORMULARY OF THE HEALTH BENEFIT PLAN; OR

(II) 1. THAT HAS AN AB–RATED GENERIC EQUIVALENT OR AN INTERCHANGEABLE BIOLOGICAL PRODUCT PREFERRED UNDER THE FORMULARY OF THE HEALTH BENEFIT PLAN; AND

2. TO WHICH THE BENEFICIARY HAS OBTAINED ACCESS THROUGH A PRIOR AUTHORIZATION, STEP THERAPY PROTOCOL, OR EXCEPTION OR APPEAL PROCESS OF THE CARRIER.

(2) SUBJECT TO PARAGRAPHS ~~(2) AND (3)~~ (3) AND (4) 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)~~ (3) IF THE APPLICATION OF THE REQUIREMENT UNDER PARAGRAPH ~~(1)~~ (2) 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.

1 ~~(3)~~ (4) **FOR ITEMS OR SERVICES THAT ARE PREVENTIVE CARE IN**
2 **ACCORDANCE WITH § 223(C)(2)(C) OF THE INTERNAL REVENUE CODE, THE**
3 **REQUIREMENTS OF THIS SUBSECTION SHALL APPLY REGARDLESS OF WHETHER THE**
4 **BENEFICIARY SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE**
5 **INTERNAL REVENUE CODE.**

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

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

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

Approved:

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Governor.

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President of the Senate.

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Speaker of the House of Delegates.