HOUSE BILL 1246

J5 5lr3479
HB 879/24 – HGO

By: ~~**Delegate S. Johnson**~~ **Delegates S. Johnson, Alston, Bagnall, Bhandari, Cullison, Guzzone, Hill, Kaiser, Kerr, Kipke, Lopez, Martinez, Pena–Melnyk, Rosenberg, Ross, Taveras, White Holland, Woods, and Woorman**

Introduced and read first time: February 7, 2025
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 1, 2025

CHAPTER _____

AN ACT concerning

Health Benefit Plans – Calculation of Cost–Sharing Contribution – Requirements

FOR the purpose of requiring certain insurers, nonprofit health service plans, and health maintenance organizations to include certain discounts, financial assistance payments, product vouchers, and other out–of–pocket expenses made by or on behalf of an insured or enrollee when calculating certain cost–sharing contributions for certain prescription drugs; requiring certain persons that provide certain discounts, financial assistance payments, product vouchers, or other out–of–pocket expenses to notify an insured or enrollee of certain information and to provide the discount, financial assistance payment, product voucher, or other out–of–pocket expense for a certain period of time; prohibiting certain insurers, nonprofit health service plans, and health maintenance organizations from setting, altering, implementing, or conditioning the terms of certain coverage based on the availability or amount of financial or product assistance available for a prescription drug; providing that a violation of a certain provision of this Act is considered a violation of the Consumer Protection Act; and generally relating to the calculation of cost sharing requirements.

BY adding to
Article – Insurance
Section 15–118.1
Annotated Code of Maryland

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

(2017 Replacement Volume and 2024 Supplement)

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) THIS SECTION APPLIES TO:

(I) 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; AND

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

(2) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION THAT PROVIDES COVERAGE FOR PRESCRIPTION DRUGS THROUGH A PHARMACY BENEFITS MANAGER IS SUBJECT TO THE REQUIREMENTS OF THIS SECTION.

(B) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, WHEN CALCULATING AN INSURED'S OR ENROLLEE'S CONTRIBUTION TO THE INSURED'S OR ENROLLEE'S COINSURANCE, COPAYMENT, DEDUCTIBLE, OR OUT–OF–POCKET MAXIMUM UNDER THE INSURED'S OR ENROLLEE'S HEALTH BENEFIT PLAN, AN ENTITY SUBJECT TO THIS SECTION SHALL INCLUDE ANY DISCOUNT, FINANCIAL ASSISTANCE PAYMENT, PRODUCT VOUCHER, OR OTHER OUT–OF–POCKET EXPENSE MADE BY OR ON BEHALF OF THE INSURED OR ENROLLEE FOR A PRESCRIPTION DRUG:

(I) THAT IS COVERED UNDER THE INSURED'S OR ENROLLEE'S HEALTH BENEFIT PLAN; AND

(II) 1. THAT DOES NOT HAVE AN AB–RATED GENERIC EQUIVALENT DRUG OR AN INTERCHANGEABLE BIOLOGICAL PRODUCT PREFERRED UNDER THE HEALTH BENEFIT PLAN'S FORMULARY; OR

2. A. THAT HAS AN AB–RATED GENERIC EQUIVALENT DRUG OR AN INTERCHANGEABLE BIOLOGICAL PRODUCT PREFERRED UNDER THE HEALTH BENEFIT PLAN'S FORMULARY; AND

B. FOR WHICH THE INSURED OR ENROLLEE ORIGINALLY OBTAINED COVERAGE THROUGH PRIOR AUTHORIZATION, A STEP THERAPY PROTOCOL, OR THE EXCEPTION OR APPEAL PROCESS OF THE ENTITY SUBJECT TO THIS SECTION.

(2) IF AN INSURED OR ENROLLEE IS COVERED UNDER A HIGH–DEDUCTIBLE HEALTH PLAN, AS DEFINED IN 26 U.S.C. § 223, THIS SUBSECTION DOES NOT APPLY TO THE DEDUCTIBLE REQUIREMENT OF THE HIGH–DEDUCTIBLE HEALTH PLAN.

(C) (1) ~~A~~ EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, A PERSON THAT PROVIDES A DISCOUNT, FINANCIAL ASSISTANCE PAYMENT, PRODUCT VOUCHER, OR OTHER OUT–OF–POCKET EXPENSE MADE BY OR ON BEHALF OF THE INSURED OR ENROLLEE THAT IS USED IN THE CALCULATION OF THE INSURED'S OR ENROLLEE'S CONTRIBUTION TO THE INSURED'S OR ENROLLEE'S COINSURANCE, COPAYMENT, DEDUCTIBLE, OR OUT–OF–POCKET MAXIMUM SHALL:

(I) WITHIN 7 DAYS AFTER THE ACCEPTANCE OF THE DISCOUNT, FINANCIAL ASSISTANCE PAYMENT, PRODUCT VOUCHER, OR OTHER OUT–OF–POCKET EXPENSE, NOTIFY THE INSURED OR ENROLLEE OF:

~~(I)~~ 1. THE MAXIMUM DOLLAR AMOUNT OF THE DISCOUNT, FINANCIAL ASSISTANCE PAYMENT, PRODUCT VOUCHER, OR OTHER OUT–OF–POCKET EXPENSE; AND

~~(II)~~ 2. THE EXPIRATION DATE FOR THE DISCOUNT, FINANCIAL ASSISTANCE PAYMENT, PRODUCT VOUCHER, OR OTHER OUT–OF–POCKET EXPENSE; AND

(II) PROVIDE THE DISCOUNT, FINANCIAL ASSISTANCE PAYMENT, PRODUCT VOUCHER, OR OTHER OUT–OF–POCKET EXPENSE FOR THE DURATION OF THE PLAN YEAR.

(2) A VIOLATION OF PARAGRAPH (1) OF THIS SUBSECTION IS A VIOLATION OF THE CONSUMER PROTECTION ACT.

(3) THIS SUBSECTION DOES NOT APPLY TO A CHARITABLE ORGANIZATION THAT PROVIDES A DISCOUNT, FINANCIAL ASSISTANCE PAYMENT, PRODUCT VOUCHER, OR OTHER OUT–OF–POCKET EXPENSE TO AN INSURED OR ENROLLEE.

(D) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, AN ENTITY SUBJECT TO THIS SECTION 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.

(2) PARAGRAPH (1) OF THIS SUBSECTION MAY NOT BE CONSTRUED TO PROHIBIT AN ENTITY SUBJECT TO THIS SECTION FROM USING REBATES IN THE DESIGN OF PRESCRIPTION DRUG COVERAGE OR BENEFITS.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health plans issued, delivered, or renewed in the State on or after January 1, 2026.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2026.

Approved:

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Governor.

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Speaker of the House of Delegates.

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President of the Senate.