SENATE BILL 773

J5 5lr1848

By: **Senator Hershey**
Introduced and read first time: January 27, 2025
Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

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

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 for certain health care services; 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 2024 Supplement)

19 Preamble

20 WHEREAS, Cost sharing assistance is indispensable in helping many patients with
21 rare, serious, and chronic diseases afford out–of–pocket costs for their essential and often
22 life–saving medications; and

23 WHEREAS, Patients need cost sharing assistance because of the high out–of–pocket
24 costs for their prescription medications; and

25 WHEREAS, When patients face unexpected charges during their health benefit plan
26 year, they are less likely to adhere to their medication regimen; and

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

WHEREAS, Lack of patient adherence to needed medications leads to potential negative health consequences such as unnecessary emergency room visits, doctors' visits, surgeries, and other interventions; and

WHEREAS, Patients are able to use cost sharing assistance only after they have met requirements for coverage for their medication, including the medication's inclusion on the patient's formulary and utilization management protocols, such as prior authorization and step therapy; and

WHEREAS, Health insurers and pharmacy benefits managers have implemented programs, such as accumulator adjustment programs, to restrict cost sharing assistance from counting toward a patient's deductible or annual out–of–pocket limit; and

WHEREAS, Because of accumulator adjustment programs, patients are required to continue to make payments even after they have reached their annual out–of–pocket limit, forcing them to pay their full deductible and annual out–of–pocket limit twice and denying them the benefit from these programs while increasing the financial burden they bear to access their life–saving medication; and

WHEREAS, Patients often are not aware of the inclusion of accumulator adjustment programs in their health plan contracts and tend to learn about these types of programs when they attempt to obtain their medication after their cost sharing assistance has run out, whether at the pharmacy, at the infusion center, or at home through the mail; and

WHEREAS, Accumulator adjustment programs allow health insurers and pharmacy benefits managers to "double dip" by accepting funds from both the cost sharing assistance program and the patient, beyond the original deductible amount and the annual out–of–pocket limit; and

WHEREAS, It is a matter of public interest to require health insurers and pharmacy benefits managers to count any amount paid by the patient or on behalf of the patient by another person toward the patient's annual out–of–pocket limit and any cost sharing requirement, such as deductibles; 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) (I) "CARRIER" MEANS AN ENTITY SUBJECT TO THE**
2 **JURISDICTION OF THE COMMISSIONER THAT CONTRACTS OR OFFERS TO CONTRACT**
3 **TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS**
4 **OF HEALTH CARE SERVICES UNDER A HEALTH BENEFIT PLAN IN THE STATE.**

5 **(II) "CARRIER" INCLUDES:**

6 **1. A HEALTH INSURANCE COMPANY;**

7 **2. A NONPROFIT HOSPITAL AND MEDICAL SERVICE**
8 **CORPORATION; AND**

9 **3. A MANAGED CARE ORGANIZATION.**

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

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

16 **(6) (I) "HEALTH BENEFIT PLAN" MEANS A POLICY, A CONTRACT, A**
17 **CERTIFICATION, OR AN AGREEMENT OFFERED OR ISSUED BY AN ADMINISTRATOR**
18 **OR A CARRIER TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY**
19 **OF THE COSTS OF HEALTH CARE SERVICES.**

20 **(II) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE A**
21 **SELF–INSURED EMPLOYEE PLAN SUBJECT TO THE FEDERAL EMPLOYEE**
22 **RETIREMENT INCOME ACT OF 1974 (ERISA).**

23 **(7) "HEALTH CARE SERVICE" MEANS AN ITEM OR A SERVICE**
24 **PROVIDED TO AN INDIVIDUAL FOR THE PURPOSE OF PREVENTING, ALLEVIATING,**
25 **CURING, OR HEALING HUMAN ILLNESS, INJURY, OR PHYSICAL DISABILITY.**

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

30 **(C) (1) SUBJECT TO PARAGRAPHS (2) AND (3) OF THIS SUBSECTION,**
31 **WHEN CALCULATING AN ENROLLEE'S CONTRIBUTION TO AN APPLICABLE COST**
32 **SHARING REQUIREMENT, AN ADMINISTRATOR OR A CARRIER SHALL INCLUDE COST**

1 SHARING AMOUNTS PAID BY THE ENROLLEE OR ON BEHALF OF THE ENROLLEE BY
2 ANOTHER PERSON.

3 (2) IF THE APPLICATION OF THE REQUIREMENT UNDER PARAGRAPH
4 (1) OF THIS SUBSECTION WOULD RESULT IN HEALTH SAVINGS ACCOUNT
5 INELIGIBILITY UNDER § 223 OF THE INTERNAL REVENUE CODE, THE REQUIREMENT
6 SHALL APPLY TO HEALTH SAVINGS ACCOUNT–QUALIFIED HIGH–DEDUCTIBLE
7 HEALTH PLANS WITH RESPECT TO THE DEDUCTIBLE OF THE PLAN AFTER THE
8 ENROLLEE SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE INTERNAL
9 REVENUE CODE.

10 (3) FOR ITEMS OR SERVICES THAT ARE PREVENTIVE CARE IN
11 ACCORDANCE WITH § 223(C)(2)(C) OF THE INTERNAL REVENUE CODE, THE
12 REQUIREMENTS OF THIS SUBSECTION SHALL APPLY REGARDLESS OF WHETHER THE
13 ENROLLEE SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE INTERNAL
14 REVENUE CODE.

15 (D) AN ADMINISTRATOR OR A CARRIER MAY NOT DIRECTLY OR INDIRECTLY
16 SET, ALTER, IMPLEMENT, OR CONDITION THE TERMS OF HEALTH BENEFIT PLAN
17 COVERAGE, INCLUDING THE BENEFIT DESIGN, BASED IN WHOLE OR IN PART ON
18 INFORMATION ABOUT THE AVAILABILITY OR AMOUNT OF FINANCIAL OR PRODUCT
19 ASSISTANCE AVAILABLE FOR A PRESCRIPTION DRUG OR BIOLOGICAL PRODUCT.

20 (E) THE COMMISSIONER MAY ADOPT REGULATIONS TO CARRY OUT THIS
21 SECTION.

22 15–1611.3.

23 (A) THIS SECTION APPLIES ONLY TO A PHARMACY BENEFITS MANAGER
24 THAT PROVIDES PHARMACY BENEFITS MANAGEMENT SERVICES ON BEHALF OF A
25 CARRIER.

26 (B) (1) SUBJECT TO PARAGRAPHS (2) AND (3) OF THIS SUBSECTION,
27 WHEN CALCULATING A BENEFICIARY'S CONTRIBUTION TO AN APPLICABLE COST
28 SHARING REQUIREMENT, A PHARMACY BENEFITS MANAGER SHALL INCLUDE COST
29 SHARING AMOUNTS PAID BY THE BENEFICIARY OR ON BEHALF OF THE BENEFICIARY
30 BY ANOTHER PERSON.

31 (2) IF THE APPLICATION OF THE REQUIREMENT UNDER PARAGRAPH
32 (1) OF THIS SUBSECTION WOULD RESULT IN HEALTH SAVINGS ACCOUNT
33 INELIGIBILITY UNDER § 223 OF THE INTERNAL REVENUE CODE, THE REQUIREMENT
34 SHALL APPLY TO HEALTH SAVINGS ACCOUNT–QUALIFIED HIGH–DEDUCTIBLE
35 HEALTH PLANS WITH RESPECT TO THE DEDUCTIBLE OF THE PLAN AFTER THE

1 **BENEFICIARY SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE**
2 **INTERNAL REVENUE CODE.**

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

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

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

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