Chapter 692

(Senate Bill 773)

AN ACT concerning

Health Benefit Plans – Calculation of ~~Cost Sharing~~ *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 a certain statement to the insured or enrollee; 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;* ~~administrators, carriers, and pharmacy benefits managers to include certain cost–sharing amounts paid by or on behalf of an enrollee or a beneficiary when calculating the enrollee's or beneficiary's contribution to a cost–sharing requirement for certain health care services; requiring administrators, carriers, and pharmacy benefits managers to include certain cost–sharing amounts for providing that the calculation requirement does not apply to enrollees in certain high–deductible health plans after an enrollee or a beneficiary satisfies a certain requirement; prohibiting administrators, carriers, and pharmacy benefits managers from directly or indirectly setting, altering, implementing, or conditioning the terms of certain coverage based on certain information; requiring third parties that pay certain financial assistance to provide certain notification to an enrollee and prohibiting the third parties from conditioning the assistance on the enrollee taking certain actions;~~ and generally relating to the calculation of cost sharing requirements.

BY adding to
Article – Insurance
Section 15–118.1 ~~and 15–1611.3~~
Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)

~~Preamble~~

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

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

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

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

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

(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.

~~**(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**~~

~~(2) "ADMINISTRATOR" HAS THE MEANING STATED IN § 8–301 OF THIS ARTICLE.~~

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

~~(I) AN INSURER;~~

~~(II) A NONPROFIT HEALTH SERVICE PLAN;~~

~~(III) A HEALTH MAINTENANCE ORGANIZATION; AND~~

~~(IV) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.~~

~~(II) "CARRIER" INCLUDES:~~

~~1. A HEALTH INSURANCE COMPANY;~~

~~2. A NONPROFIT HOSPITAL AND MEDICAL SERVICE CORPORATION; AND~~

~~3. A MANAGED CARE ORGANIZATION.~~

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

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

~~(6) (I) "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 OF THE COSTS OF HEALTH CARE SERVICES.~~

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

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

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

~~(C) (1) SUBJECT TO PARAGRAPHS (2) AND (3)~~ PARAGRAPH (2) 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) IF THE APPLICATION OF THE~~ THE REQUIREMENT UNDER PARAGRAPH (1) 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 DOES NOT APPLY WITH RESPECT TO THE DEDUCTIBLE REQUIREMENT OF A HIGH–DEDUCTIBLE HEALTH PLAN IF AN ENROLLEE IS COVERED UNDER A HIGH–DEDUCTIBLE HEALTH PLAN UNDER 26 U.S.C. § 223.

~~(3) 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) A THIRD PARTY THAT PAYS FINANCIAL ASSISTANCE IN ANY AMOUNT, OR PORTION OF THE AMOUNT, OF ANY APPLICABLE COST–SHARING OR OTHER OUT–OF–POCKET EXPENSE ON BEHALF OF AN ENROLLEE FOR A COVERED PRESCRIPTION DRUG:~~

~~(1) SHALL NOTIFY THE ENROLLEE WITHIN 7 DAYS OF THE ACCEPTANCE OF THE FINANCIAL ASSISTANCE OF THE TOTAL AMOUNT OF ASSISTANCE AVAILABLE AND THE DURATION FOR WHICH IT IS AVAILABLE; AND~~

~~(2) MAY NOT CONDITION THE ASSISTANCE ON ENROLLMENT IN A SPECIFIC HEALTH PLAN OR TYPE OF HEALTH PLAN, EXCEPT AS AUTHORIZED UNDER FEDERAL LAW.~~

~~(E) (F) THE COMMISSIONER MAY ADOPT REGULATIONS TO CARRY OUT THIS SECTION.~~

~~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) SUBJECT TO PARAGRAPHS (2) AND (3)~~ PARAGRAPH (2) ~~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 OR ON BEHALF OF THE BENEFICIARY BY ANOTHER PERSON.~~

~~(2) IF THE APPLICATION OF THE~~ THE ~~REQUIREMENT UNDER PARAGRAPH (1) 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~~ DOES NOT APPLY WITH RESPECT TO THE DEDUCTIBLE REQUIREMENT OF A HIGH–DEDUCTIBLE HEALTH PLAN IF AN ENROLLEE IS COVERED UNDER A HIGH–DEDUCTIBLE HEALTH PLAN UNDER 26 U.S.C. § 223~~.~~

~~(3) 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 BENEFICIARY SATISFIES THE MINIMUM DEDUCTIBLE UNDER § 223 OF THE INTERNAL REVENUE CODE.~~

~~(C) A PHARMACY BENEFITS MANAGER 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.~~

~~(D) A THIRD PARTY THAT PAYS FINANCIAL ASSISTANCE IN ANY AMOUNT, OR PORTION OF THE AMOUNT, OF ANY APPLICABLE COST-SHARING OR OTHER OUT-OF-POCKET EXPENSE ON BEHALF OF AN ENROLLEE FOR A COVERED PRESCRIPTION DRUG:~~

~~(1) SHALL NOTIFY THE ENROLLEE WITHIN 7 DAYS OF THE ACCEPTANCE OF THE FINANCIAL ASSISTANCE OF THE TOTAL AMOUNT OF ASSISTANCE AVAILABLE AND THE DURATION FOR WHICH IT IS AVAILABLE; AND~~

~~(2) MAY NOT CONDITION THE ASSISTANCE ON ENROLLMENT IN A SPECIFIC HEALTH PLAN OR TYPE OF HEALTH PLAN, EXCEPT AS AUTHORIZED UNDER FEDERAL LAW.~~

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit 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. *It shall remain effective for a period of 3 years and 6 months and, at the end of July 1, 2029, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.*

Approved by the Governor, May 20, 2025.