

**JOINT COMMITTEE ON FINANCIAL SERVICES
2025-2026 (194th) BILL SUMMARY**

Bill No: H1101

Title: AN ACT RELATIVE TO CONSUMER DEDUCTIBLES

Sponsor: Rep. Daniel Cahill (*Lynn*)

Hearing Date: April 29, 2025

Reporting Deadline: June 28, 2025

Prior History:

2023-24 (H953): Reported favorably; Referred to Healthcare Financing; Ordered to a House Study

2021-22 (H1053): Reported favorably; Referred to Healthcare Financing; Ordered to a House Study

2019-20 (H953): Ordered to a House Study

Similar Matters: S698 (Crighton – Identical)

CURRENT LAW:

M.G.L. c. 176O: Health Insurance Consumer Protections

42 U.S.C. § 300gg-91

(1) Health insurance coverage

The term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

42 U.S.C. §§ 18022 Essential Health Benefits Requirements (c) Requirements relating to cost-sharing

42 U.S. Code § 300gg-6 - Comprehensive health insurance coverage

(b) Cost-sharing under group health plans

A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraph (1) of section 18022(c) of this title.

(1) Annual limitation on cost-sharing

(A)2014

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of title 26 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B)2015 and later

In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under *subparagraph (A)* for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under *paragraph (4)* for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under *clause (i)*.

If the amount of any increase under *clause (i)* is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(4) Premium adjustment percentage

For purposes of *paragraph (1)(B)(i)*, the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

SUMMARY:

This bill is filed in response to health insurer and pharmacy benefit manager (PBM) copay accumulator programs. Copay accumulator programs are used by health insurance companies and Pharmacy Benefit Managers (PBMs) to prevent prescription drug manufacturer copay assistance coupons from counting towards an insured's deductible and maximum out-of-pocket costs.

The bill adds a new section to *c. 176O Health Insurance Consumer Protections*. The new section includes language that directs health insurers to include patient cost sharing amounts paid on an insured's behalf by another person, including a prescription drug manufacturer, when calculating an insured's cost sharing contribution and to apply such cost sharing or reductions towards an insured's out of pocket costs, deductible, cost sharing or similar obligation including any out-of-pocket maximum.

The following definitions are included in the section:

“Insurer” means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 U.S.C. § 300gg-91, or any state or local governmental employer plan.

“Cost sharing requirement” means any copayment, coinsurance, deductible, or annual limitation on cost sharing (including but not limited to a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan.

“Enrollee” means any individual entitled to health care services from an insurer.

“Health plan” means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care service” means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

“Person” means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government or governmental subdivision or agency.