VERMONT DEPARTMENT OF FINANCIAL REGULATION
DIVISION OF INSURANCE
INSURANCE DIVISION BULLETIN 171
OUT-OF-POCKET MAXIMUM FOR PRESCRIPTION DRUGS

Revised March 12, 2018

8 V.S.A. § 4089i, enacted as Section 32 of Act 171 of 2012, establishes an out-of-pocket maximum for prescription drugs under any insurance or other health benefit plan offered by a health insurer or a pharmacy benefit manager. This bulletin is intended to provide clarification to insurers regarding Section 4089i.

As a benchmark for the out-of-pocket maximum, the statute uses the dollar amounts specified in Internal Revenue Code Section 223(c)(2)(A)(i).

In 2012, for example, out-of-pocket expenses for prescription drugs were limited to no more than $1200 per year for individual coverage or $2400 per year for family coverage.

This Bulletin consists of some questions submitted to the Department and the Department's answers to those questions.

The Department has also received inquiries from insurers that are framed as questions about Section 4089i but in fact go to plan design or tax issues relating to Health Savings Accounts. Plan design is not addressed by Section 4089i, and as long as insurers adhere to the guidance below and the out-of-pocket maximums, Section 4089i is not implicated. Some issues, particularly as to High Deductible Health Plan (HDHP) design and the treatment of Health Savings Accounts (HSAs), are tax questions and insurers should be guided by the relevant provisions of the Internal Revenue Code (IRC) and guidance from the IRS.

FREQUENTLY ASKED QUESTIONS

What is a prescription drug?

A drug is:

- A substance recognized by an official pharmacopoeia or formulary, or
- A substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease, or
- A substance (other than food) intended to affect the structure or any function of the body, or
- A substance intended for use as a component of a medicine but not a device or a component, part, or accessory of a device.

Biological products are included within this definition, *e.g.*, monoclonal antibodies and hormonal drugs.

A "prescription drug" is any drug which is dispensed to the insured by prescription.

Does the statute require that the prescription drug out-of-pocket maximum for all plans be no higher than the federal statutory annual minimum deductible for HDHP with HSA plans?

Yes. The annual out-of-pocket maximum for prescription drugs uses as a benchmark the federal statutory annual minimum deductible set by Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986. This applies to "any insurance or other health benefit plan offered by a health insurer" including HDHPs with or without HSAs. 8 V.S.A. § 4089i.

Does the new law apply to all plans, including large group, small group, non-group, and catamount?

Yes, to the extent allowed by federal law.

Does the out-of-pocket maximum apply to all drug plans administered by the health plan, including by its PBM? If the health plan does not provide prescription drug benefits and the employer buys a separate prescription drug plan, does the new law apply?

Yes.

Which expenses count toward the out-of-pocket maximum?

An "out-of-pocket expenditure" is defined by statute to include deductibles, copays, coinsurance, and any other cost-sharing mechanism. 8 V.S.A. § 4089i(e)(2). By definition, all such expenses incurred by the insured for prescription drugs—those that are applicable to the deductible as well as all copays and coinsurance—count toward the out-of-pocket maximum.

Which expenses count toward the deductible?

The statute creates an out-of-pocket maximum for prescription drug expenses. The statute does not address deductibles, except to include deductible expenses for prescription drugs in the out-of-pocket maximum.

Are expenses for prescription drugs dispensed in a doctor's office, hospital, or clinic rather than a pharmacy included in the out-of-pocket maximum?

Expenses for drugs administered in a doctor's office, hospital or clinic that are not obtained by prescription through a retail or mail-order pharmacy are not required to be counted toward the out-of-pocket maximum.

Expenses for drugs that are dispensed from a retail or mail-order pharmacy by prescription but administered in a doctor's office, hospital, or clinic count toward the out-of-pocket maximum.

Health insurers and pharmacy benefit managers are prohibited from requiring that a drug be dispensed or administered in a doctor's office, hospital, or clinic when that drug would be available through prescription at a retail or mail-order pharmacy.

Health insurers and pharmacy benefit managers are encouraged to educate insureds about drugs that may either be (1) dispensed directly by a provider or (2) obtained by prescription in a retail or mail-order pharmacy, so that the insured understands the cost implications of choosing one method of delivery over the other.

Does Vermont law require a separate out-of-pocket maximum for prescription drugs or can it accumulate to the overall plan out-of-pocket maximum?

No. Section 4089i does not prevent an insurer from establishing one out-of-pocket maximum for the overall plan and applying prescription drug expenses to that out-of-pocket maximum, provided the insured's prescription drug costs are limited to the amount prescribed by statute. Section 4089i simply requires that all health insurance or other health benefit plans limit out-of-pocket expenses for prescription drugs. The limit is benchmarked to the federal statutory annual minimum deductible set by IRC Section 223(c)(2)(A)(i).

Does Vermont law require that the deductible for all HDHPs be no higher than the federal statutory annual minimum deductible set by IRC section 223(c)(2)(a)(i)?

No. Section 4089i simply sets an out-of-pocket maximum for prescription drugs that uses as a benchmark the federal statutory annual minimum deductible set by IRC Section 223(c)(2)(A)(i) is met. Determination of a particular HDHP plan's deductible relates to plan design.

When do prescription drug benefits begin under HDHPs?

Prescription drug benefits begin when the insured has met the federal statutory annual minimum deductible set by Section 223(c)(2)(A)(i). The Vermont statute does *not* mandate that the deductible for all HDHPs be the equivalent of the federal statutory annual minimum deductible, however, once the federal statutory annual minimum deductible is met, the insurer must begin prescription drug coverage. For family HDHPs, the federal statutory minimum annual deductible in effect for family coverage under IRC Section 223(c)(2)(A)(i)(II) must be met before prescription drug coverage begins.

Which expenses count toward HDHP deductibles for purposes of determining when prescription drug benefits must begin?

Section 4089i requires only that as to an HDHP, prescription drug benefits begin when an insured has met the federal statutory minimum deductible set in IRC Section 223(c)(2)(A)(i). The expenses that apply to this minimum deductible may depend on IRS requirements as to a particular plan design. An insurer is advised to consult the IRS on these matters.

Is the HDHP subsection of section 4089i structured so that a health plan can use different deductibles for medical services and prescription drugs?

Section 4089i does not prevent an insurer from establishing different deductibles for medical benefits and for prescription drug benefits nor does it prevent an HDHP from using a higher deductible for medical benefits than for prescription drug benefits provided the out-of-pocket maximum for prescription drug expenses is adhered to. As noted above, HDHP plan design may

be impacted by other provisions of the IRC. An insurer is advised to consult the IRS on these matters.

In an HDHP, do out-of-pocket expenses for prescription drugs incurred before the deductible is met count toward the out-of-pocket maximum for prescription drugs?

Yes.

Do differentials incurred by a patient solely because they choose a branded drug where a generic would suffice count toward the out-of-pocket maximum?

No.

Do out-of-network prescription drug expenses count toward the out-of-pocket maximum?

Yes. Deductibles, copays, or coinsurance applicable to out-of-network prescription drug purchases count toward the out-of-pocket maximum. If the insurer subjects the insured to a penalty for out-of-network purchases of prescription drugs in addition to the applicable cost-sharing expense the penalty is not applied to the out-of-pocket maximum.

What about prescription drugs as preventive medication?

Deductibles, copays, or coinsurance applicable to drugs prescribed as preventive medication apply to the prescription drug out-of-pocket maximum.

Do expenses for diabetic supplies or durable medical equipment count toward the out-of-pocket maximum?

Section 4089i establishes an out-of-pocket maximum for prescription drugs. Diabetic supplies and durable medical equipment, even when dispensed by a pharmacy or covered under a pharmacy benefit, are not prescription drugs.

Should the 2013 inflation adjusted numbers cited in the IRC Section 223(c)(2)(a)(i) apply for groups renewing in the months of October, November, and December of 2012; or do the 2012 values apply for the remaining months of 2012, with a switch to the 2013 maximums in January?

One reason for using the Section 223(c)(2)(A)(i) benchmark was to preserve HSAs. Therefore, the IRS rules on the applicable minimum annual deductible should be followed. The insurer may wish to seek tax advice on this point.

Dated at Montpelier, Vermont this 12th day of March 2018

Michael S. Pieciak, Commissioner
Vermont Department of Financial Regulation