§4317-A. Prescription drug coverage; out-of-pocket expenses for coinsurance

1. Out-of-pocket expenses for coinsurance within health plan's total limit. If a carrier that provides coverage for prescription drugs does not include prescription drugs subject to coinsurance under the total out-of-pocket limit for all benefits provided under a health plan, the carrier shall establish a separate out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.

[PL 2011, c. 611, §1 (NEW); PL 2011, c. 611, §2 (AFF).]

2. Adjustment of out-of-pocket limits. A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section. Any adjustment made by a carrier pursuant to this subsection is considered a minor modification under section 2850-B.

[PL 2011, c. 611, §1 (NEW); PL 2011, c. 611, §2 (AFF).]

3. Construction. This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in accordance with this chapter.

[PL 2011, c. 611, §1 (NEW); PL 2011, c. 611, §2 (AFF).]

4. Terms consistent with federal law. For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.

[PL 2011, c. 611, §1 (NEW); PL 2011, c. 611, §2 (AFF).]

SECTION HISTORY

PL 2011, c. 611, §1 (NEW). PL 2011, c. 611, §2 (AFF).