Department of Legislative Services

Maryland General Assembly
2017 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 768 (Senator Feldman, *et al.*)
Finance

Health Insurance - Prescription Drugs - Formulary Changes

This bill prohibits certain insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers), during a plan year and the preceding open enrollment period, from (1) removing a prescription drug from a formulary; (2) moving a prescription drug to a benefit tier that requires a higher deductible, copayment, or coinsurance; or (3) except at the time of enrollment or issuance of coverage, adding a "utilization management restriction" to a prescription drug in the formulary.

The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2017.

Fiscal Summary

State Effect: Minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) in FY 2018 from the $125 rate and form filing fee. Review of filings can likely be handled with existing MIA resources. Expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State Plan) are not affected, as discussed below.

Local Effect: Potential increase in health care expenditures for local governments that purchase fully insured health benefit plans. Revenues are not affected.

Small Business Effect: Minimal.

Analysis

Bill Summary: "Utilization management restriction" means a restriction on coverage for a prescription drug on a formulary, including a limit on the quantity of a prescription drug covered, a prior authorization requirement, and a step therapy protocol.

Current Law: Under § 15-831 of the Insurance Article, each carrier that uses a prescription drug formulary must provide coverage for an off-formulary drug or device if, in the judgment of the authorized prescriber, (1) there is no equivalent drug or device in the formulary or (2) an equivalent drug or device in the formulary has been ineffective or has caused or is likely to cause an adverse reaction or other harm. A decision of a carrier not to provide access to or coverage of a prescription drug or device in accordance with these requirements constitutes an adverse decision if the decision is based on a finding that the proposed drug or device is not medically necessary, appropriate, or efficient.

Under § 15-142 of the Insurance Article, "step therapy or fail-first protocol" means a protocol established by a carrier that requires a prescription drug or sequence of prescription drugs to be used by an insured or enrollee before a prescription drug ordered by a prescriber is covered. A carrier may not impose a step therapy or fail-first protocol if the step therapy drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated (*i.e.*, off-label use) or a prescriber provides supporting medical information to the carrier or pharmacy benefits manager (PBM) that a prescription drug covered by the carrier or PBM (1) was ordered for the insured or enrollee within the past 180 days and (2) based on the professional judgment of the prescriber, was effective in treating the insured or enrollee.

State Expenditures: The State Plan is largely self-insured for its medical contracts and, as such, with the exception of the one fully insured integrated health model medical plan (Kaiser), is not subject to this mandate. However, the State Plan generally provides coverage for mandated health insurance benefits. The Department of Budget and Management advises that the prescription plan under the State Plan currently includes language limiting formulary changes in this manner.

Additional Comments: Senate Bill 834/House Bill 990 of 2016 included a provision that would have prohibited a carrier that offers a qualified health plan, during a plan year and the preceding open enrollment period, from (1) removing a prescription drug from a formulary; (2) moving a prescription drug to a benefit tier that requires an enrollee to pay greater cost sharing; or (3) adding a utilization management restriction to a prescription drug in the formulary. The bills would have permitted a carrier to move a prescription drug to a benefit tier that requires greater cost sharing if, at the same time, the carrier adds to the formulary an AB-rated generic drug for the prescription drug.

Additional Information

Prior Introductions: None.

Cross File: HB 1128 (Delegate Kelly) - Health and Government Operations.

Information Source(s): Department of Budget and Management; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

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