HOUSE BILL 754

By: Delegate Kipke
Introduced and read first time: February 8, 2019
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning Health Insurance and Pharmacy Benefits Managers – Cost Pricing and Reimbursement

FOR the purpose of authorizing a pharmacist or a pharmacy to decline to dispense a prescription drug or provide a pharmacy service to a certain member if the amount reimbursed by a certain insurer, nonprofit health service plan, or health maintenance organization is less than a certain acquisition cost; requiring that each contract between a pharmacy benefits manager and a contracted pharmacy include a certain process to appeal, investigate, and resolve disputes regarding cost pricing and reimbursement, rather than only maximum allowable cost pricing; requiring that the appeals process include a requirement that a pharmacy benefits manager provide a certain formulary under certain circumstances; repealing the authority of a pharmacy benefits manager to retroactively deny or modify reimbursement to a pharmacy or pharmacist for an approved claim that caused certain monetary loss; defining a certain term; providing for the application of certain provisions of this Act; and generally relating to cost pricing and reimbursement of prescription drugs.

BY adding to

Article – Insurance
Section 15–1012 and 15–1628.2
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

BY repealing

Article – Insurance
Section 15–1628.1(f) through (i)
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, with amendments,

Article – Insurance

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–1012.

(A) IN THIS SECTION, “MEMBER” MEANS AN INDIVIDUAL ENTITLED TO HEALTH CARE BENEFITS FOR PRESCRIPTION DRUGS OR PHARMACY SERVICES UNDER A POLICY OR CONTRACT ISSUED OR DELIVERED IN THE STATE BY AN ENTITY SUBJECT TO THIS SECTION.

(B) (1) THIS SECTION APPLIES TO:

(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE COVERAGE FOR PRESCRIPTION DRUGS AND PHARMACY SERVICES UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

(II) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE COVERAGE FOR PRESCRIPTION DRUGS AND PHARMACY SERVICES 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 AND PHARMACY SERVICES THROUGH A PHARMACY BENEFITS MANAGER IS SUBJECT TO THE REQUIREMENTS OF THIS SECTION.

(C) IF THE AMOUNT REIMBURSED BY AN ENTITY SUBJECT TO THIS SECTION FOR A PRESCRIPTION DRUG OR PHARMACY SERVICE IS LESS THAN THE PHARMACY ACQUISITION COST FOR THE SAME PRESCRIPTION DRUG OR PHARMACY SERVICE, THE PHARMACIST OR PHARMACY MAY DECLINE TO DISPENSE THE PRESCRIPTION DRUG OR PROVIDE THE PHARMACY SERVICE TO A MEMBER.

15–1628.1.

[(f) Each contract between a pharmacy benefits manager and a contracted pharmacy must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes:
(1) a requirement that an appeal be filed by the contract pharmacy no later than 21 days after the date of the initial adjudicated claim;

(2) a requirement that, within 21 days after the date the appeal is filed, the pharmacy benefits manager investigate and resolve the appeal and report to the contracted pharmacy on the pharmacy benefits manager’s determination on the appeal;

(3) a requirement that a pharmacy benefits manager make available on its website information about the appeal process, including:

   (i) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals;

   (ii) an e-mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and

   (iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e-mail made by a contracted pharmacy to the individual within 3 business days or less of receiving the call or e-mail;

(4) a requirement that a pharmacy benefits manager provide:

   (i) a reason for any appeal denial; and

   (ii) the national drug code of a drug and the name of the wholesale distributor from which the drug was available on the date the claim was adjudicated at a price at or below the maximum allowable cost determined by the pharmacy benefits manager; and

(5) if an appeal is upheld, a requirement that a pharmacy benefits manager:

   (i) for the appealing pharmacy:

      1. adjust the maximum allowable cost for the drug as of the date of the original claim for payment; and

      2. without requiring the appealing pharmacy to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with the pharmacy benefits manager:

         A. for the original claim, in the first remittance to the pharmacy after the date the appeal was determined; and
B. for subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was determined; and

(ii) for a similarly situated contracted pharmacy in the State:

1. adjust the maximum allowable cost for the drug as of the date the appeal was determined; and

2. provide notice to the pharmacy or pharmacy’s contracted agent that:

   A. an appeal has been upheld; and

   B. without filing a separate appeal, the pharmacy or the pharmacy’s contracted agent may reverse and rebill a similar claim.

(g) A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal under this section or filing a complaint with the Commissioner under this subsection.

(h) A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from carrying out the requirement of a contract specified in subsection (f)(5) of this section or the upholding of an appeal under subsection (i) of this section.

(i) (1) If a pharmacy benefits manager denies an appeal and a contracted pharmacy files a complaint with the Commissioner, the Commissioner shall:

   (i) review the compensation program of the pharmacy benefits manager to ensure that the reimbursement for pharmacy benefits management services paid to the pharmacist or a pharmacy complies with this subtitle and the terms of the contract; and

   (ii) based on a determination made by the Commissioner under item (i) of this paragraph, dismiss the appeal or uphold the appeal and order the pharmacy benefits manager to pay the claim or claims in accordance with the Commissioner’s findings.

(2) All pricing information and data collected by the Commissioner during a review required by paragraph (1) of this subsection:

   (i) is considered to be confidential and proprietary information; and

   (ii) is not subject to disclosure under the Public Information Act.]
(A) In this section, "contracted pharmacy" means a pharmacy that participates in the network of a pharmacy benefits manager through a contract with:

(1) the pharmacy benefits manager; or

(2) a pharmacy services administration organization or a group purchasing organization.

(B) Each contract between a pharmacy benefits manager and a contracted pharmacy must include a process to appeal, investigate, and resolve disputes regarding cost pricing and reimbursement that includes:

(1) a requirement that an appeal be filed by the contract pharmacy not later than 21 days after the date of the initial adjudicated claim;

(2) a requirement that, within 21 days after the date the appeal is filed, the pharmacy benefits manager investigate and resolve the appeal and report to the contracted pharmacy on the pharmacy benefits manager's determination on the appeal;

(3) a requirement that a pharmacy benefits manager make available on its website information about the appeal process, including:

(I) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals;

(II) an e-mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and

(III) a notice indicating that the individual responsible for processing appeals shall return a call or an e-mail made by a contracted pharmacy to the individual within 3 business days or less after receiving the call or e-mail;
(4) A REQUIREMENT THAT A PHARMACY BENEFITS MANAGER PROVIDE:

(I) A REASON FOR ANY APPEAL DENIAL; AND

(II) 1. THE NATIONAL DRUG CODE OF A DRUG AND THE NAME OF THE WHOLESALE DISTRIBUTOR FROM WHICH THE DRUG WAS AVAILABLE ON THE DATE THE CLAIM WAS ADJUDICATED AT A PRICE AT OR BELOW THE MAXIMUM ALLOWABLE COST DETERMINED BY THE PHARMACY BENEFITS MANAGER; OR

2. IF THE PHARMACY BENEFITS MANAGER DOES NOT USE MAXIMUM ALLOWABLE COST IN DETERMINING THE AMOUNT OF REIMBURSEMENT TO A PHARMACY OR PHARMACIST, THE FORMULARY USED TO DETERMINE THE AMOUNT OF REIMBURSEMENT; AND

(5) IF AN APPEAL IS UPHELD, A REQUIREMENT THAT A PHARMACY BENEFITS MANAGER:

(I) FOR THE APPEALING PHARMACY:

1. ADJUST THE COST OR REIMBURSEMENT FOR THE DRUG AS OF THE DATE OF THE ORIGINAL CLAIM FOR PAYMENT; AND

2. WITHOUT REQUIRING THE APPEALING PHARMACY TO REVERSE AND REBILL THE CLAIMS, PROVIDE REIMBURSEMENT FOR THE CLAIM AND ANY SUBSEQUENT AND SIMILAR CLAIMS UNDER SIMILARLY APPLICABLE CONTRACTS WITH THE PHARMACY BENEFITS MANAGER:

A. FOR THE ORIGINAL CLAIM, IN THE FIRST REMITTANCE TO THE PHARMACY AFTER THE DATE THE APPEAL WAS DETERMINED; AND

B. FOR SUBSEQUENT AND SIMILAR CLAIMS UNDER SIMILARLY APPLICABLE CONTRACTS, IN THE SECOND REMITTANCE TO THE PHARMACY AFTER THE DATE THE APPEAL WAS DETERMINED; AND

(II) FOR A SIMILARLY SITUATED CONTRACTED PHARMACY IN THE STATE:

1. ADJUST THE COST OR REIMBURSEMENT FOR THE DRUG AS OF THE DATE THE APPEAL WAS DETERMINED; AND

2. PROVIDE NOTICE TO THE PHARMACY OR PHARMACY'S CONTRACTED AGENT THAT:
A. AN APPEAL HAS BEEN UPHELD; AND

B. WITHOUT FILING A SEPARATE APPEAL, THE PHARMACY OR THE PHARMACY’S CONTRACTED AGENT MAY REVERSE AND REBILL A SIMILAR CLAIM.

(C) A PHARMACY BENEFITS MANAGER MAY NOT RETALIATE AGAINST A CONTRACTED PHARMACY FOR EXERCISING ITS RIGHT TO APPEAL UNDER THIS SECTION OR FILING A COMPLAINT WITH THE COMMISSIONER UNDER THIS SECTION.

(D) A PHARMACY BENEFITS MANAGER MAY NOT CHARGE A CONTRACTED PHARMACY A FEE RELATED TO THE READJUDICATION OF A CLAIM OR CLAIMS RESULTING FROM CARRYING OUT THE REQUIREMENT OF A CONTRACT SPECIFIED IN SUBSECTION (B)(5) OF THIS SECTION OR THE UPHOLDING OF AN APPEAL UNDER SUBSECTION (E) OF THIS SECTION.

(E) (1) IF A PHARMACY BENEFITS MANAGER DENIES AN APPEAL AND A CONTRACTED PHARMACY FILES A COMPLAINT WITH THE COMMISSIONER, THE COMMISSIONER SHALL:

(I) REVIEW THE COMPENSATION PROGRAM OF THE PHARMACY BENEFITS MANAGER TO ENSURE THAT THE REIMBURSEMENT FOR PHARMACY BENEFITS MANAGEMENT SERVICES PAID TO THE PHARMACIST OR A PHARMACY COMPLIES WITH THIS SUBTITLE AND THE TERMS OF THE CONTRACT; AND

(II) BASED ON A DETERMINATION MADE BY THE COMMISSIONER UNDER ITEM (I) OF THIS PARAGRAPH, DISMISS THE APPEAL OR UPHOLD THE APPEAL AND ORDER THE PHARMACY BENEFITS MANAGER TO PAY THE CLAIM OR CLAIMS IN ACCORDANCE WITH THE COMMISSIONER’S FINDINGS.

(2) ALL PRICING INFORMATION AND DATA COLLECTED BY THE COMMISSIONER DURING A REVIEW REQUIRED BY PARAGRAPH (1) OF THIS SUBSECTION:

(I) IS CONSIDERED TO BE CONFIDENTIAL AND PROPRIETARY INFORMATION; AND

(II) IS NOT SUBJECT TO DISCLOSURE UNDER THE PUBLIC INFORMATION ACT.

15–1631.

Except for an overpayment as defined in § 15–1629(h) of this subtitle, if a claim has
been approved by a pharmacy benefits manager through adjudication, the pharmacy
benefits manager may not retroactively deny or modify reimbursement to a pharmacy or
pharmacist for the approved claim unless:

(1) the claim was fraudulent;

(2) the pharmacy or pharmacist had been reimbursed for the claim previously; OR

(3) the services reimbursed were not rendered by the pharmacy or pharmacist; or

(4) subject to § 15–1629(h)(2) of this part, the claim otherwise caused monetary loss to the pharmacy benefits manager, provided that the pharmacy benefits manager allowed the pharmacy a reasonable opportunity to remedy the cause of the monetary loss.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2019.