

SENATE BILL 819

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CF 9lr1832

By: **Senators Hayes and Hershey**

Introduced and read first time: February 4, 2019

Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Pharmaceutical Manufacturers – Transparency and Reporting

FOR the purpose of requiring the Secretary of Health, by a certain date each year, to identify up to a certain number of certain prescription drugs on which the State spends a certain amount of money; requiring the Secretary to require the manufacturer of a certain drug to report certain information; requiring that the information reported by the manufacturer be consistent with the level and type of data made available in certain filings and data sources; requiring the Secretary to establish certain standardized forms; requiring the Secretary, by a certain date each year, to publish a certain report on the Maryland Department of Health's website; prohibiting the disclosure of certain information in a certain manner; requiring a certain carrier to make available on the carrier's website in a certain manner certain information related to prescription drugs; prohibiting the carrier from requiring certain information in order to access the information; requiring a carrier to report certain information to the Maryland Insurance Commissioner by a certain date each year; requiring a carrier to provide certain individuals certain written notice at least a certain number of days before the effective date of any changes in the member's pharmaceutical benefit; requiring the notice to be consistent with certain notices provided under certain provisions of law; requiring a certain carrier, beginning on a certain date, to disclose that a member may be subject to certain cost sharing; requiring the disclosure to be included in certain documents; prohibiting the carrier from publishing or otherwise revealing information about certain rebates in the disclosure; requiring a carrier to impose certain confidentiality protections on certain persons; requiring each pharmacy benefits manager to provide a certain report to the Commissioner by a certain date each year; requiring the Commissioner to publish on the Maryland Insurance Administration's website certain information in a certain manner; prohibiting a pharmacy benefits manager and the Commissioner from disclosing certain information; establishing the confidentiality of certain information and prohibiting the information from being disclosed; requiring a pharmacy benefits manager to publish in a certain manner a certain formulary and

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



notification of formulary changes on or before a certain date each year; prohibiting a county or municipality from enacting a law regulating certain matters; defining certain terms; altering certain definitions; and generally relating to transparency and reporting requirements for pharmaceutical manufacturers.

BY adding to

Article – Health – General

Section 2–1001 and 2–1002 to be under the new subtitle “Subtitle 10. Transparency and Reporting for Pharmaceutical Manufacturers”

Annotated Code of Maryland

(2015 Replacement Volume and 2018 Supplement)

BY adding to

Article – Insurance

Section 15–144, 15–145, and 15–1612.1

Annotated Code of Maryland

(2017 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, with amendments,

Article – Insurance

Section 15–1601

Annotated Code of Maryland

(2017 Replacement Volume and 2018 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
That the Laws of Maryland read as follows:

Article – Health – General

**SUBTITLE 10. TRANSPARENCY AND REPORTING FOR PHARMACEUTICAL
MANUFACTURERS.**

2–1001.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) “PRESCRIPTION DRUG” MEANS A DRUG THAT MAY BE DISPENSED ONLY ON THE PRESCRIPTION OF A HEALTH CARE PRACTITIONER WHO IS AUTHORIZED BY LAW TO PRESCRIBE THE DRUG.

(C) “REBATES” MEANS ALL REBATES, DISCOUNTS, OR OTHER PRICE CONCESSIONS THAT THE STATE OR ANOTHER PAYER RECEIVES OR EXPECTS TO RECEIVE, DIRECTLY OR INDIRECTLY, FROM A PHARMACEUTICAL MANUFACTURER RELATED TO THE USE OF PRESCRIPTION DRUGS PRODUCED BY THE PHARMACEUTICAL MANUFACTURER.

(D) “RESEARCH AND DEVELOPMENT EXPENDITURES” MEANS ALL COSTS THAT A PHARMACEUTICAL MANUFACTURER INCURS DURING A CALENDAR YEAR THAT RELATE TO THE RESEARCH AND DEVELOPMENT OF NEW PRODUCTS, PROCESSES, OR SERVICES, AND INCLUDES COSTS OF RESEARCH AND DEVELOPMENT OF PRODUCTS, PROCESSES, OR SERVICES THAT THE PHARMACEUTICAL MANUFACTURER HAS ACQUIRED OR OBTAINED VIA A LICENSE.

(E) “WHOLESALE ACQUISITION COST” HAS THE MEANING STATED IN 42 U.S.C. § 1395W-3A.

2-1002.

(A) (1) ON OR BEFORE MARCH 1, 2020, AND EACH MARCH 1 THEREAFTER, THE SECRETARY SHALL IDENTIFY UP TO 10 PRESCRIPTION DRUGS ON WHICH THE STATE SPENDS SIGNIFICANT HEALTH CARE DOLLARS, AFTER ACCOUNTING FOR REBATES, AND FOR WHICH THE WHOLESALE ACQUISITION COST HAS INCREASED BY A TOTAL OF 50% OR MORE DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(2) THE DRUGS IDENTIFIED UNDER THIS SUBSECTION SHALL REPRESENT DIFFERENT DRUG CLASSES AND INCLUDE GENERIC DRUGS.

(B) FOR EACH PRESCRIPTION DRUG IDENTIFIED UNDER SUBSECTION (A) OF THIS SECTION, THE SECRETARY SHALL REQUIRE THE MANUFACTURER OF THE DRUG TO REPORT:

(1) A SCHEDULE OF THE DRUG’S WHOLESALE ACQUISITION COST INCREASES DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR;

(2) THE MANUFACTURER’S AGGREGATE, COMPANY-LEVEL RESEARCH AND DEVELOPMENT EXPENDITURES AND OTHER RELEVANT CAPITAL EXPENDITURES FOR THE MOST RECENT YEAR FOR WHICH FINAL AUDITED DATA ARE AVAILABLE; AND

(3) A WRITTEN DESCRIPTION, IN PLAIN LANGUAGE, OF FACTORS THAT CONTRIBUTED TO THE REPORTED INCREASES IN WHOLESALE ACQUISITION COST DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(C) (1) INFORMATION REPORTED BY A MANUFACTURER UNDER SUBSECTION (B) OF THIS SECTION SHALL BE CONSISTENT WITH THE LEVEL AND TYPE OF DATA MADE AVAILABLE IN THE MANUFACTURER’S FORM 10-K FILINGS

WITH THE U.S. SECURITIES AND EXCHANGE COMMISSION OR OTHER PUBLICALLY AVAILABLE DATA SOURCES.

(2) THE SECRETARY, IN CONSULTATION WITH STAKEHOLDERS, SHALL ESTABLISH A STANDARDIZED FORM FOR REPORTING INFORMATION UNDER SUBSECTION (B) OF THIS SECTION.

(D) ON OR BEFORE JUNE 1, 2020, AND EACH JUNE 1 THEREAFTER, THE SECRETARY SHALL PUBLISH A REPORT ON THE DEPARTMENT'S WEBSITE BASED ON THE INFORMATION THAT THE SECRETARY RECEIVES UNDER SUBSECTION (B) OF THIS SECTION.

(E) INFORMATION PROVIDED TO THE SECRETARY UNDER SUBSECTION (B) OF THIS SECTION:

(1) SHALL BE CONSIDERED A TRADE SECRET AND CONFIDENTIAL COMMERCIAL INFORMATION, INCLUDING UNDER § 4-335 OF THE GENERAL PROVISIONS ARTICLE;

(2) IS NOT SUBJECT TO PUBLIC INSPECTION; AND

(3) MAY NOT BE DISCLOSED IN A MANNER THAT WOULD ALLOW FOR THE IDENTIFICATION OF AN INDIVIDUAL DRUG, THERAPEUTIC CLASS OF DRUGS, OR MANUFACTURER, OR IN A MANNER THAT IS LIKELY TO COMPROMISE THE FINANCIAL, COMPETITIVE, OR PROPRIETARY NATURE OF THE INFORMATION.

(F) A COUNTY OR MUNICIPALITY MAY NOT ENACT A LAW THAT REGULATES PHARMACEUTICAL MANUFACTURERS' DISCLOSURES OF REVENUE-RELATED, EXPENSE-RELATED, AND DRUG PRICING-RELATED INFORMATION SUBJECT TO THIS SECTION.

Article – Insurance

15-144.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED:

(2) "CARRIER" MEANS:

(I) A HEALTH INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A MANAGED CARE ORGANIZATION AS DEFINED IN § 15-101 OF THE HEALTH – GENERAL ARTICLE THAT PROVIDES COVERAGE FOR PRESCRIPTION DRUGS; OR

(V) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

(3) “FORMULARY” MEANS A LIST OF PRESCRIPTION DRUGS THAT HAS BEEN DEVELOPED BY A CARRIER OR THE DESIGNEE OF A CARRIER, THAT THE CARRIER OR DESIGNEE REFERENCES IN DETERMINING APPLICABLE COVERAGE AND BENEFIT LEVELS.

(4) “HEALTH BENEFIT PLAN” MEANS A POLICY, A CONTRACT, A CERTIFICATE, OR AN AGREEMENT THAT IS OFFERED, ISSUED, OR DELIVERED BY A CARRIER TO AN INDIVIDUAL OR A GROUP IN THE STATE TO PROVIDE, DELIVER, ARRANGE FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

(5) (I) “MEMBER” MEANS AN INDIVIDUAL ENTITLED TO HEALTH CARE SERVICES FROM A CARRIER UNDER A POLICY OR PLAN THAT IS ISSUED OR DELIVERED IN THE STATE.

(II) “MEMBER” INCLUDES AN INSURED OR A SUBSCRIBER.

(B) EACH CARRIER THAT OFFERS ONE OR MORE HEALTH BENEFIT PLANS FOR SALE IN THE STATE SHALL MAKE THE FOLLOWING INFORMATION AVAILABLE ON THE CARRIER’S WEBSITE IN AN EASILY ACCESSIBLE MANNER:

(1) THE CARRIER’S CURRENT FORMULARY, INCLUDING EACH PRESCRIPTION DRUG COVERED UNDER THE CARRIER’S PRESCRIPTION DRUG BENEFIT AND OUTPATIENT MEDICAL BENEFIT THAT IS ADMINISTERED BY A HEALTH PROFESSIONAL OR UNDER THE DIRECT SUPERVISION OF A HEALTH PROFESSIONAL OR ADMINISTERED IN AN OUTPATIENT SETTING, IN A FORMAT THAT IS ELECTRONICALLY SEARCHABLE BY:

(I) PRESCRIPTION DRUG NAME;

(II) TYPE OF HEALTH BENEFIT PLAN; AND

(III) ANY OTHER MEANS REQUIRED BY THE COMMISSIONER; AND

(2) A DESCRIPTION, IN PLAIN LANGUAGE, OF HOW TO ACCESS INFORMATION ABOUT:

(I) ANY PRIOR AUTHORIZATION, STEP THERAPY, QUANTITY LIMIT, PHARMACY RESTRICTION, OR OTHER PHARMACEUTICAL BENEFIT MANAGEMENT PROGRAM LIMITATION TO ACCESS OF A PRESCRIPTION DRUG UNDER THE CARRIER'S HEALTH BENEFIT PLAN; AND

(II) COST-SHARING FOR EACH PRESCRIPTION DRUG ON THE FORMULARY, INCLUDING INFORMATION ABOUT WHETHER THE PRESCRIPTION DRUG IS SUBJECT TO A DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT, AND THE EXTENT TO WHICH THE COST-SHARING VARIES DEPENDING ON THE NUMBER OF DAYS' SUPPLY OF THE PRESCRIPTION DRUG.

(C) A CARRIER MAY NOT REQUIRE AN ACCOUNT, A PLAN, OR A POLICY NUMBER IN ORDER TO ACCESS THE INFORMATION MADE AVAILABLE UNDER SUBSECTION (B) OF THIS SECTION.

(D) ON OR BEFORE MARCH 1, 2020, AND EACH MARCH 1 THEREAFTER, EACH CARRIER THAT OFFERS ONE OR MORE HEALTH BENEFIT PLANS FOR SALE IN THE STATE SHALL REPORT TO THE COMMISSIONER FOR EACH HEALTH BENEFIT PLAN:

(1) THE NUMBER OF RECONSIDERATION REQUESTS, GRIEVANCES, AND APPEALS THAT THE CARRIER RECEIVED IN RESPONSE TO DENIALS OF PRIOR AUTHORIZATION REQUESTS DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR; AND

(2) THE AVERAGE NUMBER OF HOURS THAT PASSED BETWEEN THE TIME THAT THE CARRIER RECEIVED A RECONSIDERATION REQUEST, A GRIEVANCE, OR AN APPEAL IN RESPONSE TO A DENIAL OF A PRIOR AUTHORIZATION REQUEST, AND THE TIME THAT THE CARRIER ISSUED THE CARRIER'S FINAL DECISION DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(E) (1) EACH CARRIER THAT OFFERS ONE OR MORE HEALTH BENEFIT PLANS FOR SALE IN THE STATE AND THAT PROVIDES PHARMACEUTICAL BENEFITS TO ITS MEMBERS SHALL PROVIDE EACH MEMBER WITH WRITTEN NOTICE AT LEAST 30 DAYS BEFORE THE EFFECTIVE DATE OF ANY CHANGES IN THE MEMBER'S PHARMACEUTICAL BENEFIT, INCLUDING AN EXCLUSION OF COVERAGE FOR CLASSES OF DRUGS OR A CHANGE IN PRIOR AUTHORIZATION PROCEDURES OR REQUIREMENTS.

(2) THE WRITTEN NOTICE PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE CONSISTENT WITH WRITTEN NOTICE THAT THE CARRIER PROVIDES TO ALL IN-NETWORK PHARMACIES UNDER § 15-107(B)(1) AND (2) OF THIS SUBTITLE.

15-145.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) “CARRIER” HAS THE MEANING STATED IN § 15-144 OF THIS SUBTITLE.

(3) “EXCESS COST SHARING” MEANS A DEDUCTIBLE PAYMENT, COPAYMENT, OR COINSURANCE AMOUNT THAT A CARRIER CHARGES TO A MEMBER FOR A COVERED PRESCRIPTION DRUG AND THAT IS GREATER THAN THE AMOUNT THAT A MEMBER’S HEALTH BENEFIT PLAN CARRIER WOULD PAY ABSENT THAT MEMBER COST SHARING, AFTER ACCOUNTING FOR REBATES.

(4) “REBATE” MEANS:

(I) A NEGOTIATED PRICE CONCESSION, INCLUDING BASE REBATES AND REASONABLE ESTIMATES OF ANY PRICE PROTECTION REBATES AND PERFORMANCE-BASED REBATES THAT MAY ACCRUE DIRECTLY OR INDIRECTLY TO THE CARRIER DURING THE COVERAGE YEAR FROM A MANUFACTURER, DISPENSING PHARMACY, OR OTHER PARTY TO THE TRANSACTION; AND

(II) A REASONABLE ESTIMATE OF ANY FEES AND OTHER ADMINISTRATIVE COSTS THAT ARE PASSED THROUGH TO THE CARRIER AND SERVE TO REDUCE THE CARRIER’S PRESCRIPTION DRUG LIABILITIES FOR A PARTICULAR COVERAGE YEAR.

(B) (1) BEGINNING JANUARY 1, 2020, A CARRIER THAT CHARGES MEMBERS COST SHARING AMOUNTS THAT MAY RESULT IN EXCESS COST SHARING FOR COVERED PRESCRIPTIONS SHALL DISCLOSE THAT MEMBERS MAY BE SUBJECT TO EXCESS COST SHARING.

(2) THE DISCLOSURE REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE INCLUDED IN HEALTH BENEFIT PLAN DOCUMENTS, INCLUDING EVIDENCE OF COVERAGE MATERIALS, FORMULARIES OR PREFERRED DRUG GUIDES, AND MARKETING MATERIALS.

(C) (1) IN MAKING THE REQUIRED DISCLOSURE UNDER SUBSECTION (B) OF THIS SECTION, A CARRIER MAY NOT PUBLISH OR OTHERWISE REVEAL INFORMATION REGARDING THE AMOUNT OF REBATES THE CARRIER RECEIVES, INCLUDING INFORMATION REGARDING THE AMOUNT OF REBATES THE CARRIER RECEIVES ON A PRODUCT-SPECIFIC, MANUFACTURER-SPECIFIC, OR PHARMACY-SPECIFIC BASIS.

(2) THE INFORMATION DESCRIBED UNDER PARAGRAPH (1) OF THIS SUBSECTION:

(I) IS PROTECTED AS A TRADE SECRET;

(II) IS NOT A PUBLIC RECORD IN ACCORDANCE WITH § 4-335 OF THE GENERAL PROVISIONS ARTICLE; AND

(III) MAY NOT BE DISCLOSED EITHER DIRECTLY OR INDIRECTLY.

(3) A CARRIER SHALL IMPOSE THE CONFIDENTIALITY PROTECTIONS UNDER THIS SECTION ON ANY VENDOR, THIRD PARTY THAT PERFORMS HEALTH CARE, OR ADMINISTRATIVE SERVICE ACTING ON BEHALF OF THE CARRIER THAT MAY RECEIVE OR HAVE ACCESS TO REBATE INFORMATION.

(D) A COUNTY OR MUNICIPALITY MAY NOT ENACT A LAW THAT REGULATES CARRIER DISCLOSURES SUBJECT TO THIS SECTION.

15-1601.

(a) In this subtitle the following words have the meanings indicated.

(B) “ADMINISTRATIVE FEES” MEANS FEES OR PAYMENTS FROM PHARMACEUTICAL MANUFACTURERS TO, OR OTHERWISE RETAINED BY, A PHARMACY BENEFITS MANAGER OR THE DESIGNEE OF A PHARMACY BENEFITS MANAGER, IN ACCORDANCE WITH A CONTRACT BETWEEN A PHARMACY BENEFITS MANAGER OR AFFILIATE AND THE MANUFACTURER, IN CONNECTION WITH THE PHARMACY BENEFIT MANAGER’S ADMINISTRATION, INVOICING, ALLOCATION, AND COLLECTION OF THE PAYMENTS OF THE MANUFACTURER.

[(b)] (C) “Agent” means a pharmacy, a pharmacist, a mail order pharmacy, or a nonresident pharmacy acting on behalf or at the direction of a pharmacy benefits manager.

(D) (1) “AGGREGATE RETAINED MANUFACTURER PAYMENT PERCENTAGE” MEANS THE PERCENTAGE OF ALL MANUFACTURER PAYMENTS THAT A PHARMACY BENEFITS MANAGER RECEIVES FROM ALL PHARMACEUTICAL MANUFACTURERS THAT IS NOT PASSED ON TO THE PHARMACY BENEFITS

MANAGER'S HEALTH BENEFIT PLAN OR TO PURCHASER CLIENTS, EXPRESSED WITHOUT DISCLOSING ANY IDENTIFYING INFORMATION REGARDING ANY HEALTH BENEFIT PLAN, PRESCRIPTION DRUG, OR THERAPEUTIC CLASS.

(2) "AGGREGATE RETAINED MANUFACTURER PAYMENT PERCENTAGE" EQUALS:

(I) THE AGGREGATE DOLLAR AMOUNT OF ALL MANUFACTURER PAYMENTS THAT THE PHARMACY BENEFITS MANAGER RECEIVES DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR FROM ALL PHARMACEUTICAL MANUFACTURERS AND THAT DO NOT PASS THROUGH TO A HEALTH BENEFIT PLAN, OR TO PURCHASER CLIENTS DURING THE SAME PRIOR CALENDAR YEAR; DIVIDED BY

(II) THE AGGREGATE DOLLAR AMOUNT OF ALL MANUFACTURER PAYMENTS THAT THE PHARMACY BENEFITS MANAGER RECEIVES DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR FROM ALL PHARMACEUTICAL MANAGERS.

[(c)] (E) "Beneficiary" means an individual who receives prescription drug coverage or benefits from a purchaser.

[(d)] (F) "ERISA" has the meaning stated in § 8-301 of this article.

[(e)] (G) "Formulary" means a list of prescription drugs used by a purchaser.

[(f)] (H) (1) "Manufacturer payments" means any compensation or remuneration a pharmacy benefits manager receives from or on behalf of a pharmaceutical manufacturer.

(2) "Manufacturer payments" includes:

(i) payments received in accordance with agreements with pharmaceutical manufacturers for formulary placement and, if applicable, drug utilization;

(ii) rebates, regardless of how categorized;

(iii) market share incentives;

(iv) commissions;

(v) fees under products and services agreements;

(vi) any fees received for the sale of utilization data to a pharmaceutical manufacturer; **[and]**

(vii) administrative or management fees; AND

(VIII) ANY DISCOUNTS OR OTHER PRICE CONCESSIONS, BASED ON THE USE OF A PRESCRIPTION DRUG AND PAID BY A PHARMACEUTICAL MANUFACTURER OR OTHER PARTY, OTHER THAN AN ENROLLEE, DIRECTLY OR INDIRECTLY, TO A PHARMACY BENEFITS MANAGER AFTER A PHARMACY ADJUDICATES A CLAIM.

[(3) “Manufacturer payments” does not include purchase discounts based on invoiced purchase terms.]

[(g)] **(I)** “Nonprofit health maintenance organization” has the meaning stated in § 6–121(a) of this article.

[(h)] **(J)** “Nonresident pharmacy” has the meaning stated in § 12–403 of the Health Occupations Article.

[(i)] **(K)** “Pharmacist” has the meaning stated in § 12–101 of the Health Occupations Article.

[(j)] **(L)** “Pharmacy” has the meaning stated in § 12–101 of the Health Occupations Article.

[(k)] **(M)** “Pharmacy and therapeutics committee” means a committee established by a pharmacy benefits manager to:

- (1) objectively appraise and evaluate prescription drugs; and
- (2) make recommendations to a purchaser regarding the selection of drugs for the purchaser’s formulary.

[(l)] **(N)** (1) “Pharmacy benefits management services” means:

(i) the procurement of prescription drugs at a negotiated rate for dispensation within the State to beneficiaries;

(ii) the administration or management of prescription drug coverage provided by a purchaser for beneficiaries; and

(iii) any of the following services provided with regard to the administration of prescription drug coverage:

1. mail service pharmacy;
2. claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;

3. clinical formulary development and management services;
4. rebate contracting and administration;
5. patient compliance, therapeutic intervention, and generic substitution programs; or
6. disease management programs.

(2) “Pharmacy benefits management services” does not include any service provided by a nonprofit health maintenance organization that operates as a group model, provided that the service:

- (i) is provided solely to a member of the nonprofit health maintenance organization; and
- (ii) is furnished through the internal pharmacy operations of the nonprofit health maintenance organization.

[(m)] (O) “Pharmacy benefits manager” means a person that performs pharmacy benefits management services.

[(n)] (P) “Proprietary information” means:

- (1) a trade secret;
- (2) confidential commercial information; or
- (3) confidential financial information.

[(o)] (Q) (1) “Purchaser” means the State Employee and Retiree Health and Welfare Benefits Program, an insurer, a nonprofit health service plan, **[or]** a health maintenance organization, **OR ANY OTHER PERSON THAT PROVIDES A HEALTH BENEFIT PLAN SUBJECT TO REGULATION BY THE STATE** that:

- (i) provides prescription drug coverage or benefits in the State; and
- (ii) enters into an agreement with a pharmacy benefits manager for the provision of pharmacy benefits management services.

(2) “Purchaser” does not include a person that provides prescription drug coverage or benefits through plans subject to ERISA and does not provide prescription drug coverage or benefits through insurance, unless the person is a multiple employer welfare arrangement as defined in § 514(b)(6)(a)(ii) of ERISA.

(R) “PURCHASER ADMINISTRATIVE SERVICE FEE” MEANS A FEE OR PAYMENT FROM A PURCHASER OR A DESIGNEE OF A PURCHASER TO, OR OTHERWISE RETAINED BY, A PHARMACY BENEFITS MANAGER OR THE PHARMACY BENEFITS MANAGER’S DESIGNEE IN ACCORDANCE WITH A CONTRACT BETWEEN A PHARMACY BENEFITS MANAGER OR AFFILIATE AND THE PURCHASER OR DESIGNEE OF THE PURCHASER IN CONNECTION TO THE MANAGEMENT OR ADMINISTRATION OF THE PHARMACY BENEFIT BY THE PHARMACY BENEFITS MANAGER, AND THE ADMINISTRATION, INVOICING, ALLOCATION, AND COLLECTION OF MANUFACTURER PAYMENTS.

[(p)] (S) “Rebate sharing contract” means a contract between a pharmacy benefits manager and a purchaser under which the pharmacy benefits manager agrees to share manufacturer payments with the purchaser.

[(q)] (T) (1) “Therapeutic interchange” means any change from one prescription drug to another.

(2) “Therapeutic interchange” does not include:

- (i) a change initiated pursuant to a drug utilization review;
- (ii) a change initiated for patient safety reasons;
- (iii) a change required due to market unavailability of the currently prescribed drug;
- (iv) a change from a brand name drug to a generic drug in accordance with § 12–504 of the Health Occupations Article; or
- (v) a change required for coverage reasons because the originally prescribed drug is not covered by the beneficiary’s formulary or plan.

[(r)] (U) “Therapeutic interchange solicitation” means any communication by a pharmacy benefits manager for the purpose of requesting a therapeutic interchange.

[(s)] (V) “Trade secret” has the meaning stated in § 11–1201 of the Commercial Law Article.

15–1612.1.

(A) ON OR AFTER JANUARY 1, 2020, AND EACH JANUARY 1 THEREAFTER, EACH PHARMACY BENEFITS MANAGER SHALL PROVIDE THE COMMISSIONER WITH A REPORT THAT CONTAINS THE FOLLOWING INFORMATION FROM THE IMMEDIATELY PRECEDING CALENDAR YEAR REGARDING PHARMACY BENEFITS PROVIDED TO ENROLLEES IN THE STATE:

(1) THE AGGREGATE DOLLAR AMOUNT OF ALL MANUFACTURER PAYMENTS THAT A PHARMACY BENEFITS MANAGER RECEIVED FROM ALL PHARMACEUTICAL MANUFACTURERS;

(2) THE AGGREGATE DOLLAR AMOUNT OF ALL ADMINISTRATIVE FEES THAT THE PHARMACY BENEFITS MANAGER RECEIVED;

(3) THE AGGREGATE DOLLAR AMOUNT OF ALL PURCHASER ADMINISTRATIVE SERVICE FEES THAT THE PHARMACY BENEFITS MANAGER RECEIVED;

(4) THE AGGREGATE DOLLAR AMOUNT OF ALL MANUFACTURER PAYMENTS THAT THE PHARMACY BENEFITS MANAGER RECEIVED FROM ALL PHARMACEUTICAL MANUFACTURERS AND THAT DID NOT PASS THROUGH TO HEALTH BENEFITS PLANS OR PURCHASERS;

(5) THE AGGREGATE DOLLAR AMOUNT OF ALL ADMINISTRATIVE FEES THAT THE PHARMACY BENEFITS MANAGER RECEIVED FROM ALL PHARMACEUTICAL MANUFACTURERS AND THAT DID NOT PASS THROUGH TO HEALTH BENEFITS PLANS OR PURCHASERS;

(6) THE AGGREGATE RETAINED MANUFACTURER PAYMENT PERCENTAGE; AND

(7) THE HIGHEST AND THE LOWEST AGGREGATE RETAINED MANUFACTURER PAYMENT PERCENTAGE ACROSS ALL OF THE PHARMACY BENEFITS MANAGER'S CONTRACTUAL RELATIONSHIPS OR OTHER RELATIONSHIPS WITH ALL HEALTH BENEFITS PLANS AND PURCHASERS.

(B) (1) THE COMMISSIONER SHALL PUBLISH, IN A TIMELY MANNER, THE INFORMATION THAT THE ADMINISTRATION RECEIVES UNDER SUBSECTION (A) OF THIS SECTION ON THE ADMINISTRATION'S WEBSITE.

(2) THE INFORMATION PUBLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE MADE AVAILABLE IN A FORM THAT DOES NOT DISCLOSE:

(I) THE IDENTITY OF A SPECIFIC PURCHASER;

(II) THE PRICES CHARGED FOR SPECIFIC DRUGS OR CLASSES OF DRUGS; OR

(III) THE AMOUNT OF ANY MANUFACTURER PAYMENTS PROVIDED FOR SPECIFIC DRUGS OR CLASSES OF DRUGS.

(C) (1) THE PHARMACY BENEFITS MANAGER AND THE COMMISSIONER MAY NOT PUBLISH OR OTHERWISE DISCLOSE ANY INFORMATION THAT WOULD REVEAL:

(I) THE IDENTITY OF A SPECIFIC PURCHASER OR A PHARMACEUTICAL MANUFACTURER;

(II) THE PRICES CHARGED FOR A SPECIFIC DRUG OR CLASS OF DRUGS; OR

(III) THE AMOUNT OF ANY MANUFACTURER PAYMENTS PROVIDED FOR A SPECIFIC DRUG OR CLASS OF DRUGS.

(2) THE INFORMATION DESCRIBED IN PARAGRAPH (1) OF THIS SUBSECTION:

(I) SHALL BE CONSIDERED A TRADE SECRET AND CONFIDENTIAL COMMERCIAL INFORMATION, INCLUDING UNDER § 4-335 OF THE GENERAL PROVISIONS ARTICLE; AND

(II) IS NOT SUBJECT TO PUBLIC INSPECTION.

(D) ON OR BEFORE MARCH 1, 2020, AND EACH MARCH 1 THEREAFTER, FOR EACH OF THE PHARMACY BENEFITS MANAGER'S CONTRACTS OR OTHER RELATIONSHIPS WITH A PURCHASER, THE PHARMACY BENEFITS MANAGER SHALL PUBLISH ON A PUBLICLY ACCESSIBLE WEBSITE THE PURCHASER'S FORMULARY AND NOTIFICATION OF FORMULARY CHANGES OR PRODUCT EXCLUSIONS WITHIN 60 DAYS BEFORE THE EFFECTIVE DATE OF THE CHANGE.

(E) THE COMMISSIONER, IN CONSULTATION WITH STAKEHOLDERS, SHALL ESTABLISH A STANDARDIZED FORM FOR REPORTING THE INFORMATION REQUIRED UNDER THIS SECTION.

(F) A COUNTY OR MUNICIPALITY MAY NOT ENACT A LAW THAT REGULATES PHARMACY BENEFITS MANAGER DISCLOSURES SUBJECT TO THIS SECTION.

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