Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 785 (Delegate Morgan, *et al.*)
Health and Government Operations

Health Insurance and Pharmacy Benefits Managers - Freedom of Choice of Pharmacy Act

This bill establishes a series of prohibitions against certain actions being taken by a "carrier" that provides, directly or through a pharmacy benefits manager (PBM), coverage for pharmacy services. Each pharmacy must be eligible to participate in the health benefit plan under identical reimbursement terms and conditions. A pharmacy may not waive, discount, rebate, or modify an enrollee's copayment, coinsurance requirement, or reimbursement for prescription drug coverage under a health benefit plan. A PBM is prohibited from requiring a beneficiary to use a mail order pharmacy to fill or refill a prescription drug as a condition for reimbursing the cost of the drug. The bill also repeals several provisions of current law relating to pharmacy choice and specialty pharmacies. **The bill takes effect on January 1, 2021, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Special fund revenues increase minimally for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2021 only. MIA review of additional filings may necessitate contractual support in FY 2021 only. No effect on the State Employee and Retiree Health and Welfare Benefits Program.

Local Effect: The bill does not have a material impact on local government finances.

Small Business Effect: Meaningful.

Analysis

Bill Summary: "Carrier" means an insurer, a nonprofit health service plan, a health maintenance organization, or any other person that provides health benefit plans subject to State regulation.

If a carrier limits coverage and reimbursement of pharmacy services to contracting pharmacies, the carrier must, by March 1, 2020 [*sic*], (1) provide written notice to each pharmacy within the geographical service area of the health benefit plan of the network established by the carrier and (2) offer to the pharmacy the opportunity to participate in the health benefit plan during the next plan year.

A carrier may not:

- prohibit an enrollee from selecting, or limit the ability of an enrollee to select, a pharmacy of the enrollee's choice if the pharmacy participates as a contract provider in the health benefit plan offered by the carrier;
- deny a pharmacy the right to participate as a contract provider under a health benefit plan if the pharmacy agrees to (1) provide pharmacy services in a manner that meets the carrier's terms and conditions and (2) the carrier's terms of reimbursement;
- impose on an enrollee a copayment, fee, or condition for a pharmacy service from a contract provider that is different from the copayment, fee, or condition imposed on all other enrollees for the same pharmacy service under the health benefit plan;
- impose a monetary advantage or penalty, including a higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another, that may affect an enrollee's choice of pharmacy;
- because of an enrollee's selection of a pharmacy of the enrollee's choice, reduce allowable reimbursement for an enrollee's pharmacy services under a health benefit plan if the pharmacy has agreed to participate in the health benefit plan under terms and conditions offered to all pharmacies under the health benefit plan;
- require an enrollee to purchase pharmacy services exclusively through a mail order pharmacy as a condition of payment or reimbursement; or
- impose on an enrollee a copayment, an amount of reimbursement, a limitation on the number of days of a drug supply, or any other payment or condition that is costlier or more restrictive than what would be imposed on the enrollee if the same pharmacy service were purchased from a mail order pharmacy.

If a pharmacy provides a pharmacy service to an enrollee that meets the terms and conditions of the health benefit plan, the pharmacy must offer the same pharmacy service to all enrollees of the health benefit plan under the same terms and conditions established by the carrier.

On an annual basis, a carrier must inform the enrollees of a health benefit plan offered by the carrier of the names and locations of pharmacies that are participating in the health benefit plan. A pharmacy may inform its customers of the pharmacy's participation in a health benefit plan network through a means that is acceptable to the pharmacy and the carrier.

Current Law: Health insurance policies or contracts issued by an insurer or nonprofit health service plan that provide benefits for pharmaceutical products may not impose a copayment, deductible, or other condition on an insured or certificate holder who uses the services of a community pharmacy that is not imposed when the insured or certificate holder uses the services of a mail order pharmacy, if the benefits are provided under the same program, policy, or contract. A nonprofit health service plan that provides pharmaceutical services must allow a subscriber, member, or beneficiary to fill prescriptions at the pharmacy of their choice.

An entity may require a covered specialty drug to be obtained through a designated pharmacy or other specified source or a pharmacy participating in the entity's provider network, if the entity determines that the pharmacy meets the entity's performance standards and accepts the entity's network reimbursement rates.

A pharmacy registered under § 340B of the federal Public Health Services Act may apply to an entity to be a designated specialty pharmacy for the purpose of enabling the pharmacy's patients with HIV, AIDS, or hepatitis C to receive a specified copayment or coinsurance maximum if the pharmacy is owned by a federally qualified health center that provides integrated and coordinated medical and pharmaceutical services to HIV positive, AIDS, and hepatitis C patients and the prescription drugs are covered specialty drugs for the treatment of HIV, AIDS, or hepatitis C.

A PBM is a business that administers and manages prescription drug benefit plans for purchasers. A PBM must register with MIA prior to providing pharmacy benefits management services. The Insurance Commissioner is authorized to examine the affairs, transactions, accounts, and records of a registered PBM at the PBM's expense. A PBM is prohibited from shipping, mailing, or delivering prescription drugs or devices to a person in the State through a nonresident pharmacy unless the nonresident pharmacy holds a nonresident pharmacy permit from the State Board of Pharmacy.

Background: According to the National Community Pharmacists Association, some patients are limited from accessing their pharmacy of choice or are financially penalized for having prescriptions filled at a community pharmacy rather than a "preferred pharmacy." Further, community pharmacies are rarely offered an opportunity to match or beat the price in order to remain "in the network" with the same access to those patients.

"Any willing provider" or "any authorized provider" statutes require health insurance carriers to allow health care providers to become members of the carriers' networks if certain conditions are met. Such statutes prohibit insurance carriers from limiting membership within their provider networks based upon geography or other characteristics, so long as a provider is willing and able to meet the conditions of network membership set by the carrier. According to the National Conference of State Legislatures, as of November 2014, 27 states had such statutes, including Delaware, Virginia, and West Virginia.

Under federal law and regulations, Medicare Part D (prescription drug) plan sponsors must permit the participation of any pharmacy that meets the sponsors' standard terms and conditions.

Small Business Effect: Small business pharmacies benefit from the opportunity to participate in provider networks.

Additional Information

Prior Introductions: Substantially similar legislation has been introduced in recent legislative sessions. HB 545 of 2019 received a hearing in the House Health and Government Operations Committee but was withdrawn. HB 1527 of 2018 and its cross file, SB 1075, were both withdrawn. HB 1121 of 2017 received a hearing in the House Health and Government Operations Committee but was withdrawn. Its cross file, SB 1054, was withdrawn.

Designated Cross File: None.

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

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