SB 438

Department of Legislative Services

Maryland General Assembly
2025 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 438 (Senator Lam)
Finance

Pharmacy Benefits Administration - Maryland Medical Assistance Program and Pharmacy Benefits Managers

This emergency bill requires Medicaid to establish minimum reimbursement levels for drug products with a generic equivalent that are at least equal to the National Average Drug Acquisition Cost (NADAC) of the generic product plus the fee-for-service (FFS) professional dispensing fee. If a prescriber directs a specific brand name drug, reimbursement must be based on the NADAC of the brand name product plus the FFS professional dispensing fee. These requirements do not apply to (1) a pharmacy owned by, or under the same corporate affiliation as, a pharmacy benefits manager (PBM) or (2) a mail order pharmacy. A PBM that contracts with a pharmacy on behalf of a Medicaid managed care organization (MCO) must reimburse the pharmacy in an amount that is at least equal to the NADAC plus the FFS professional dispensing fee. The bill modifies the definition of "purchaser" to specify that it includes an insurer, nonprofit health service plan, or health maintenance organization (HMO), with the exception of a group model HMO.

Fiscal Summary

State Effect: Medicaid expenditures (50% general funds, 50% federal funds) increase by a significant but indeterminate amount, likely by millions of dollars in FY 2025 and tens of millions of dollars beginning in FY 2026, as discussed below. Federal fund revenues increase accordingly. Expenditures for the State Employee and Retiree Health and Welfare Benefits Program may increase beginning in FY 2025, as discussed below. **This bill increases the cost of an entitlement program beginning in FY 2025.**

Local Effect: None.

Small Business Effect: Meaningful.

Analysis

Current Law:

Medicaid Reimbursement for Prescription Drugs

Medicaid must establish maximum reimbursement levels for the drug products for which there is a generic equivalent based on the cost of the generic product. If the prescriber directs a brand name drug, the reimbursement level must be based on the cost of the brand name product.

Chapter 534 of 2019, among other things, required Medicaid to contract with an independent auditor for an audit of PBMs that contract with Medicaid MCOs and provide the results to the General Assembly.

Outpatient pharmacy coverage is an optional benefit under Medicaid. Reimbursement for prescription drugs varies between FFS Medicaid (which covers about 15% of Medicaid enrollees) and HealthChoice (under which Medicaid MCOs cover about 85% of Medicaid enrollees).

In FFS, Medicaid reimburses pharmacies based on a two-part formula consisting of the ingredient cost of the drug and the professional dispensing fee. Effective April 2017, Maryland adopted the NADAC methodology to calculate the ingredient cost of the drug. This methodology estimates the national average drug invoice price paid by independent and retail chain pharmacies. For any drug not included in NADAC, the State uses its own State actual acquisition cost (SAAC) as a secondary benchmark. Thus, for FFS pharmacy expenditures, Medicaid reimburses pharmacies as follows:

- the ingredient cost of the drug based on NADAC or a provider's usual and customary charges, whichever is lower; if there is no NADAC, the lowest of the wholesale acquisition cost, the federal upper limit, SAAC, or a provider's usual and customary charges; and
- a professional dispensing fee of $10.67 for brand name and generic drugs.

In HealthChoice, all nine Medicaid MCOs use a PBM. PBM reimbursement amounts are proprietary and confidential. However, pursuant to Chapter 217 of 2023, the Maryland Department of Health (MDH) and the Prescription Drug Affordability Board submitted a report to the General Assembly in November 2023 that provided specified data, as follows:

- the total amount that MCOs paid pharmacies for pharmacy claims in calendar 2021 and 2022;

- what the total amount paid to pharmacies in calendar 2021 and 2022 would have been if pharmacy claims had been reimbursed at Medicaid FFS rates; and
- the projected fiscal impact if the dispensing fees paid by MCOs to pharmacies were to change based on the claims and reimbursement data for calendar 2022.

The report noted that the total amount paid in ingredient costs by MCOs collectively in both calendar 2021 and 2022 was higher than what it would have been if the MCO pharmacy claims were paid using the FFS reimbursement methodology. In calendar 2022, MCOs paid approximately $1.228 billion in pharmacy claims; the report found that if the claims had been paid using the FFS methodology, the total cost would have been approximately $1.195 billion. Accordingly, if MCOs had used the FFS methodology in calendar 2022, they would have achieved savings for ingredient costs of approximately $32.8 million.

With respect to professional dispensing fees, the data showed that MCOs paid $6.6 million in such fees for pharmacy claims in calendar 2022. If those fees had instead been paid using the FFS methodology, the report estimated that MCOs would have spent approximately $117.7 million on professional dispensing fees in calendar 2022. That would have equated to an increase of approximately $111.1 million for professional dispensing fees paid by MCOs in calendar 2022.

Overall, the report concluded that total costs for MCO pharmacy claims in calendar 2022 would have increased by approximately $78.3 million if they had paid pharmacy claims using the FFS reimbursement methodology. However, the report did not reflect what proportion of claims were paid to pharmacies owned by or under the same corporate affiliation as a PBM or to mail order pharmacies.

Definition of Purchaser Relating to Pharmacy Benefits Managers

Chapter 358 of 2021 defined "carrier" and altered the definition of "purchaser," including repealing the exclusion of plans subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), for purposes of State law governing PBMs. The Act, among other things, (1) applied specified provisions governing PBMs to self-funded ERISA plans; (2) altered the applicability of certain PBM requirements to apply to a carrier (rather than a purchaser); and (3) specified that certain provisions apply only to a PBM that provides pharmacy benefits management services on behalf of a carrier.

"Carrier" means the State Employee and Retiree Health and Welfare Benefits Program, an insurer, a nonprofit health service plan, or an HMO that provides prescription drug coverage or benefits in the State and enters into an agreement with a PBM for the provision of pharmacy benefits management services. "Carrier" 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 under ERISA.

"Purchaser" means a person that offers a plan or program in the State, including the State Employee and Retiree Health and Welfare Benefits Program, that (1) provides prescription drug coverage or benefits in the State and (2) enters into an agreement with a PBM for the provision of pharmacy benefits management services.

State Expenditures:

Medicaid Reimbursement for Prescription Drugs

According to MDH, Medicaid expenditures increase significantly because of the higher reimbursement rates that MCOs must pay to pharmacies for dispensing prescription drugs. MDH estimates that Medicaid expenditures increase by $16.8 million (50% general funds, 50% federal funds) in fiscal 2025, which assumes April 1, 2025 implementation of the emergency bill. Medicaid's estimate reflects the additional cost for PBMs used by all nine Medicaid MCOs to reimburse for prescription drugs as specified under the bill. In subsequent years, Medicaid advises that expenditures increase by an estimated $68.4 million in fiscal 2026, $69.8 million in fiscal 2027, $71.2 million in fiscal 2028, and $72.6 million in fiscal 2029. Expenditures are eligible for a 50% federal matching rate in fiscal 2025 and subsequent years.

However, MDH's estimate *does not* reflect that the bill's minimum reimbursement requirements do not apply to a pharmacy owned by, or under the same corporate affiliation as, a PBM or to a mail order pharmacy. Accordingly, the Department of Legislative Services (DLS) advises that while Medicaid expenditures likely increase by millions of dollars in fiscal 2025 and tens of millions of dollars in subsequent years, DLS cannot reliably estimate the bill's overall impact on Medicaid expenditures at this time.

State Employee and Retiree Health and Welfare Benefits

The State Employee and Retiree Health and Welfare Benefits Program is largely self-insured for its medical contracts and, as such, except for the one fully insured integrated health model medical plan (Kaiser), is not subject to this bill. However, the program generally provides coverage as otherwise required under State law.

The Department of Budget and Management (DBM) advises that the bill's requirements increase annual costs to the program by tens of millions of dollars. According to DBM, this is because the program has negotiated dispensing fees of $0.35 and $0.50 per script in place for active members and retirees, respectively.

If DBM elects to comply with the bill's requirements, DLS agrees that annual expenditures for the State Employee and Retiree Health and Welfare Benefits Program increase significantly.

Small Business Effect: Small business pharmacies benefit from increased professional dispensing fees for Medicaid MCO enrollees, particularly those pharmacies that serve a high proportion of Medicaid enrollees.

Additional Comments: It is unclear if the bill's provision exempting pharmacies owned by, or under the same corporate affiliation as, a PBM and mail order pharmacies from the minimum reimbursement rates are legally permissible on equal protection and commerce clause grounds.

Additional Information

Recent Prior Introductions: Similar legislation has been introduced within the last three years. See HB 880 and SB 1021 of 2024; HB 382 (first reader) and SB 895 of 2023; and HB 1007 of 2022.

Designated Cross File: HB 813 (Delegates S. Johnson and A. Johnson) - Health and Government Operations.

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

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