Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE

Senate Bill 854 (Senator Garagiola)
Finance Health and Government Operations

Health Insurance - Definition of Coverage Decisions - Pharmacy Inquiries

This bill excludes a "pharmacy inquiry" from the definition of coverage decision for purposes of the internal appeals process for carrier coverage decisions and subsequent complaints to the Maryland Insurance Commissioner.

Fiscal Summary

State Effect: The bill does not substantively change State activities or operations.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: A "pharmacy inquiry" is an inquiry submitted by a pharmacist or pharmacy on behalf of a member to a carrier or a pharmacy benefits manager (PBM) at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under a health benefit plan.

Current Law: A "coverage decision" is an initial determination by a carrier that results in noncoverage of a health care service, including nonpayment of a claim. A coverage decision does not include an adverse decision. An adverse decision is a utilization review determination by a private review agent, carrier, or health care provider acting on behalf of a carrier that a proposed or delivered health care service is or was not medically necessary, appropriate, or efficient and *may result* in noncoverage of the service. A decision concerning a subscriber's status as a member is not an adverse decision.

Each carrier must establish an internal appeal process for members and health care providers to dispute coverage decisions. Within 30 calendar days after a coverage decision is made, a carrier must send written notice of the coverage decision, including the basis for the carrier's decision and the right to appeal.

A carrier must render a final coverage decision in writing within 60 working days after the appeal is filed. Within 30 calendar days of the appeal decision, a carrier must send written notice of the appeal decision, including the basis for the carrier's decision and the right to file a complaint with the Commissioner within 60 working days of receipt of the appeal decision.

A carrier's internal appeal process must be exhausted before filing a complaint with the Commissioner, except when the coverage decision involves an urgent medical condition for which care has not been rendered. The Commissioner must make and issue in writing a final decision on all complaints and provide written notice to all parties of the opportunity and time period for requesting a hearing to contest a final decision.

Background: When filling a prescription for a patient, a pharmacist or pharmacy staff member may call a carrier or PBM to inquire as to whether a particular medication is covered, whether prior authorization is required, or the appropriate copayment amount. These pharmacy inquiries may have been interpreted as coverage decisions subject to the requirements of the appeal process.

Additional Information

Prior Introductions: None.

Cross File: HB 1071 (Delegate Kach) - Health and Government Operations.

Information Source(s): Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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