SB 405

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 405 (Senator Hayes, *et al.*)
Finance Health and Government Operations

Health Insurance - Prescription Drugs - Formulary Changes

This bill requires certain insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) that remove a drug from their formulary or move a drug to a benefit tier with a higher deductible, copayment, or coinsurance amount to provide a member and the member's health care provider with (1) notice at least 30 days before the change is implemented and (2) included in the notice, the process for requesting a specified exemption. The bill also expands the current process carriers must have in place to allow a member to receive an off-formulary prescription drug or device to include a prescription drug or device that has been removed from a formulary and to allow a member to continue the same cost-sharing requirements under specified circumstances. **The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2020.**

Fiscal Summary

State Effect: The bill does not materially affect State finances. No impact on the State Employee and Retiree Health and Welfare Benefits Program (State Plan), as discussed below.

Local Effect: Potential increase in health care expenditures for local governments that purchase fully insured health benefit plans. Revenues are not affected.

Small Business Effect: Minimal.

Analysis

Bill Summary/Current Law: Under current law, each carrier that uses a prescription drug formulary must provide coverage for an off-formulary drug or device if, in the judgment of the authorized prescriber, (1) there is no equivalent drug or device in the formulary or (2) an equivalent drug or device in the formulary has been ineffective or has caused or is likely to cause an adverse reaction or other harm.

The bill expands this process to include access to a prescription drug or device that *has been removed from the formulary*, if, in the judgment of the authorized prescriber, (1) there is no equivalent drug or device in the formulary *in a lower tier* or (2) an equivalent drug or device in the formulary *in a lower tier* has been ineffective or has caused or is likely to cause an adverse reaction or other harm. The bill also requires that each carrier's procedure authorize a member to continue the same cost-sharing requirements if the carrier has moved the prescription drug or device to a higher deductible, copayment, or coinsurance tier.

A decision of a carrier not to provide access to or coverage of a prescription drug or device in accordance with these requirements constitutes an adverse decision if the decision is based on a finding that the proposed drug or device is not medically necessary, appropriate, or efficient.

State Expenditures: The State Plan is largely self-insured for its medical contracts and, as such, with the exception of the one fully insured integrated health model medical plan (Kaiser), is not subject to this requirement. However, the State Plan generally provides coverage for mandated health insurance benefits. The Department of Budget and Management advises that the pharmacy benefits manager contract for the State Plan's prescription plan currently permits formulary changes to occur only on the first day of each plan year (currently January 1). The contract requires a 45-day advance notice to affected participants.

Additional Information

Prior Introductions: None.

Cross File: HB 435 (Delegate Kelly, *et al.*) - Health and Government Operations.

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

Fiscal Note History:	First Reader - February 18, 2019
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