**HB 601**

# Department of Legislative Services

Maryland General Assembly
2021 Session

## FISCAL AND POLICY NOTE
## Third Reader - Revised

House Bill 601 (Delegate Kipke)
Health and Government Operations Finance

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### Pharmacy Benefits Managers - Revisions

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This bill defines "carrier" and alters 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 pharmacy benefits managers (PBMs). Specified provisions governing PBMs are applied to self-funded ERISA plans. The bill also (1) alters the applicability of certain PBM requirements to apply to a *carrier* (rather than a purchaser); (2) specifies that certain provisions apply only to a PBM that provides pharmacy benefits management services on behalf of a carrier; and (3) alters requirements regarding review and approval of certain contract forms and filings by the Insurance Commissioner. By December 31, 2021, the Maryland Insurance Administration (MIA) must report to specified committees of the General Assembly on the scope of the *Rutledge v. Pharmaceutical Care Management Association* decision and how to apply the decision to the regulation of PBMs under Maryland law. **The bill takes effect January 1, 2022, and applies to a contract between a PBM and a purchaser that is a health and welfare benefit plan on the first day of the plan year beginning on or after that date.**

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## Fiscal Summary

**State Effect:** MIA can likely handle any additional workload under the bill, including increased complaint volume and submission of the required report, using existing budgeted resources. Revenues are not affected.

**Local Effect:** The bill subjects self-funded ERISA plans, including those offered by local governments and local school systems, to specified provisions of PBM regulation. Any impact on local government or local school system expenditures cannot be reliably estimated at this time. Revenues are not affected.

**Small Business Effect:** Potential meaningful.

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## Analysis

**Bill Summary:** "Carrier" means the State Employee and Retiree Health and Welfare Benefits Program, an insurer, a nonprofit health service plan, or a health maintenance organization (HMO) that (1) provides prescription drug coverage or benefits in the State and (2) enters into an agreement with a PBM for 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 such coverage or benefits through insurance, unless the person is a multiple employer welfare arrangement (MEWA) 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 pharmacy benefits management services. The bill removes an insurer, a nonprofit health service plan, or an HMO from the definition of purchaser. The bill also repeals the exclusion – from the definition of "purchaser" – of a person that provides prescription drug coverage or benefits through plans subject to ERISA and does not provide such coverage or benefits through insurance, unless the person is a MEWA.

*Application of Pharmacy Benefits Manager Provisions to a Carrier vs. a Purchaser*

The bill specifies that a *carrier* (rather than a purchaser) is prohibited from (1) entering into an agreement with a PBM that has not registered with the Commissioner and (2) directly charging or holding a contracted pharmacy responsible for a fee or performance-based reimbursement related to adjudication of a claim or an incentive program.

*Pharmacy Benefits Managers Performing Services on Behalf of a Carrier*

The bill specifies that the following provisions of law governing PBMs apply only to a PBM performing pharmacy benefits management services on behalf of a carrier:

- the prohibition against prohibiting a pharmacy or pharmacist from providing information about the retail price or cost share for a prescription drug or from selling a more affordable prescription drug to a beneficiary;
- beneficiary choice of pharmacy;
- the prohibition against reimbursing a pharmacy or pharmacist in an amount less than what a PBM reimburses itself or an affiliate;
- requirements relating to pharmacy and therapeutics committees;

- required disclosures to purchasers prior to entering a contract and nondisclosure agreements;
- requirements for rebate sharing contracts;
- required disclosures prior to entering a contract with a pharmacy or pharmacist;
- audits of pharmacies and pharmacists by PBMs;
- required internal review process; and
- limitations on and procedures for therapeutic interchanges.

For purposes of credentialing a pharmacy or a pharmacist to participate in a PBM's network *for a carrier*, a PBM may not require a pharmacy or pharmacist to renew credentialing more than once every three years or charge a fee for credentialing.

*Approval of Contract Forms between a Pharmacy Benefits Manager and a Pharmacy*

The bill repeals the requirement that, in order for a contract or contract amendment to take effect, the Commissioner must not disapprove the contract or amendment within 30 days after it is filed. The requirement that the Commissioner adopt regulations to establish the circumstances under which a contract may be disapproved is also repealed. Instead, each contract form or amendment to a contract form between a PBM and a pharmacy may not take effect unless, at least 30 days before the contract form or amendment is to become effective, the PBM files an informational filing with the Commissioner that includes a copy of the contract form or amendment. The Commissioner is not required to review the informational filing to evaluate whether a contract form or amendment is in violation of PBM law at the time the filing is made, but may review and disapprove a contract form or amendment at any time after it has been submitted as part of an informational filing.

**Current Law:** Title 15, Subtitle 16 of the Insurance Article governs PBMs. A PBM is a business that administers and manages prescription drug benefit plans for purchasers. A PBM must register with the Maryland Insurance Administration (MIA) prior to providing pharmacy benefits management services.

"Purchaser" means the State Employee and Retiree Health and Welfare Benefits Program, an insurer, a nonprofit health service plan, or an HMO 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. "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 MEWA.

*Employee Retirement Income Security Act*

ERISA contains a preemption clause stating that the Act "shall supersede any and all state laws insofar as they relate to any employee benefit plan." These benefits include health care. State reforms have often come into conflict with ERISA when they relate, directly or indirectly, to employee benefits. States cannot mandate that employers pay for health insurance, directly tax benefit plans, impose significant costs on plans, dictate the terms of an ERISA plan, or require reports on cost or use of the plans from employers. States are permitted to "regulate the business of insurance." A self-funded plan may not be regulated as insurance as ERISA specifies it is not an insurance plan.

In 2015, Arkansas passed legislation relating to PBM reimbursement that applied to "a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in this state" and was sued by the Pharmaceutical Care Management Association on grounds of ERISA preemption. The Eighth Circuit held that ERISA preempted the statute as it "related to" and "had a connection with" ERISA-governed employee benefits plans.

In December 2020, in *Rutledge v. Pharmaceutical Care Management Association*, the U.S. Supreme Court disagreed with the Eighth Circuit and held that Arkansas' law is not preempted by ERISA, concluding that "ERISA does not preempt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage" and that state regulation of an intermediary contracted by a health plan does not "directly regulate health benefit plans at all."

**Small Business Effect:** Small business pharmacies and pharmacists may benefit from the application of certain PBM provisions to self-funded ERISA plans.

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## Additional Information

**Prior Introductions:** None.

**Designated Cross File:** SB 964 (Senator Jennings) - Rules.

**Information Source(s):** Department of Budget and Management; Maryland Insurance Administration; Anne Arundel County Public Schools; Department of Legislative Services

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