HOUSE BILL 1461

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By: **Delegates Taveras, Lehman, and Williams**
Introduced and read first time: February 13, 2026
Assigned to: Health

A BILL ENTITLED

AN ACT concerning

Health Insurance – Coverage for Specialty Drugs – Rheumatologic Conditions

FOR the purpose of altering the circumstances under which certain insurers, nonprofit health service plans, and health maintenance organizations are prohibited from excluding coverage for certain specialty drugs for the treatment of rheumatologic conditions; and generally relating to health insurance coverage for specialty drugs.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–847.2
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

Preamble

WHEREAS, Specialty drugs are increasingly used to treat complex conditions such as autoimmune diseases and rheumatologic disorders; and

WHEREAS, Many patients rely on their physician's office or clinic to timely dispense and administer specialty medications, particularly when these drugs require complex dosing, clinical monitoring, or coordination with infusion therapies; and

WHEREAS, Payers and pharmacy benefit managers (PBMs) have increasingly adopted policies that steer patients to designated specialty pharmacies often owned by the payer or PBM; and

WHEREAS, Pharmacy steering practices can lead to treatment delays, shipment errors, and interruptions in care; and

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

WHEREAS, Providers dispensing specialty drugs within their clinical practice settings must comply with rigorous State regulations, maintain extensive clinical oversight, and ensure adherence, safety monitoring, and coordinated care; and

WHEREAS, Steering policies result in clinical providers being underpaid for dispensing specialty drugs while allowing higher payments to designated specialty pharmacies, creating financial disincentives that undermine patient access to office–based care; and

WHEREAS, Ensuring adequate reimbursement for specialty drugs dispensed or administered by office–based providers promotes competition and fairness across dispensing channels; and

WHEREAS, It is the intent of the Maryland General Assembly to ensure that insurers, nonprofit health service plans, and health maintenance organizations do not exclude coverage for clinically appropriate specialty drugs when administered or dispensed by qualified in–network providers who meet all State regulatory requirements; and

WHEREAS, Protecting patient choice and preserving clinically integrated care models are essential to preventing disruptions in treatment for individuals with complex and chronic conditions; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–847.2.

(a) In this section, "specialty drug" has the meaning stated in § 15–847 of this subtitle.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(c) An entity subject to this section may not exclude coverage for a covered specialty drug administered or dispensed by a provider under § 12–102 of the Health Occupations Article if the entity determines that:

(1) **(I)** the provider that administers or dispenses the covered specialty drug:

[(i)**]** **1.** is an in–network provider of covered oncology services; and

[(ii)**]** **2.** complies with State regulations for the administering and dispensing of specialty drugs; and

[(2)**]** **(II)** the covered specialty drug is:

[(i)**]** **1.** auto–injected or an oral targeted immune modulator; or

[(ii)**]** **2.** an oral medication that:

[1.**]** **A.** requires complex dosing based on clinical presentation; or

[2.**]** **B.** is used concomitantly with other infusion or radiation therapies**; OR**

(2) (I) FOR A SPECIALTY DRUG FOR THE TREATMENT OF RHEUMATOLOGIC CONDITIONS, THE PROVIDER THAT ADMINISTERS OR DISPENSES THE COVERED SPECIALTY DRUG:

1. IS AN IN–NETWORK PROVIDER OF COVERED RHEUMATOLOGY SERVICES; AND

2. COMPLIES WITH THE STATE REGULATIONS FOR THE ADMINISTERING AND DISPENSING OF SPECIALTY DRUGS; AND

(II) THE COVERED SPECIALTY DRUG IS:

1. AUTO–INJECTED OR AN ORAL TARGETED IMMUNE MODULATOR; OR

2. AN ORAL MEDICATION THAT:

A. REQUIRES COMPLEX DOSING BASED ON CLINICAL PRESENTATION; OR

B. IS USED CONCOMITANTLY WITH OTHER INFUSION THERAPIES.

(d) (1) Subject to subsection (f) of this section, the reimbursement rate for specialty drugs covered under this section shall be:

(i) agreed to by the covered, in–network provider and the entity subject to this section; and

(ii) billed at a nonhospital level of care or place of service.

(2) Unless otherwise agreed to by the covered, in–network provider and the entity subject to this section, the reimbursement rate for specialty drugs covered under this section may not exceed the rate applicable to a designated specialty pharmacy for dispensing the covered specialty drugs.

(e) This section does not prohibit an entity subject to this section from refusing to authorize or approve or from denying coverage for a covered specialty drug administered or dispensed by a provider if administering or dispensing the drug fails to satisfy medical necessity criteria.

(f) This section may not be construed to supersede the authority of the Health Services Cost Review Commission to set rates for specialty drugs administered to patients in a setting regulated by the Health Services Cost Review Commission.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2027.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2027.