



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

March 4, 2026

The Honorable Heather Bagnall
Chair, House Health Committee
Room 241, House Office Building
Annapolis, Maryland 21401

RE: House Bill 1114 – HIV Prevention Drugs – Prescribing, Dispensing, and Insurance Coverage – Letter of Information

Dear Chair Bagnall and Committee members:

The Maryland Department of Health (the Department) respectfully submits this letter of information for House Bill (HB) 1114 – HIV Prevention Drugs - Prescribing, Dispensing, and Insurance Coverage. This bill authorizes pharmacists to prescribe and dispense Pre-Exposure Prophylaxis (PrEP) for HIV, and prohibits managed care organizations, insurers, nonprofit health service plans, and health maintenance organizations from requiring prior authorization for PrEP or step therapy or cost-sharing for PrEP or postexposure prophylaxis (PEP) for HIV prevention. This bill also requires the Board of Pharmacy to develop a notification plan and convene a workgroup.

PrEP is a combination of specific antiretroviral medications designed to reduce the risk of HIV transmission through a sexual encounter or injection drug use for HIV-negative individuals. When used consistently, in conjunction with behavioral risk reduction, the risk of contracting HIV is reduced by approximately 92%.¹ More recent long-acting injectable PrEP options have shown efficacy rates of up to 100% in helping individuals remain HIV negative.²

Although highly effective, PrEP remains underutilized nationwide due to systemic and geographical barriers to traditional primary care.³ With 90% of the U.S. population living within

¹ Sundareshan, V., Mangat, R., & Koirala, J. (2022). Preexposure Prophylaxis for HIV Prevention. PubMed; StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK507789/>

² Patel, R. R., Hoover, K. W., Lale, A., Cabrales, J., Byrd, K. M., & Kourtis, A. P. (2025). Clinical Recommendation for the Use of Injectable Lenacapavir as HIV Preexposure Prophylaxis — United States, 2025. *MMWR Morbidity and Mortality Weekly Report*, 74(35), 541–549. <https://doi.org/10.15585/mmwr.mm7435a1>

³ Killelea, A., Johnson, J., Dangerfield, D. T., Beyrer, C., McGough, M., McIntyre, J., Gee, R. E., Ballreich, J., Conti, R., Horn, T., Pickett, J., & Sharfstein, J. M. (2022). Financing and Delivering Pre-Exposure Prophylaxis (PrEP) to End the HIV Epidemic. *The Journal of law, medicine & ethics : a journal of the American Society of Law, Medicine & Ethics*, 50(S1), 8–23. <https://doi.org/10.1017/jme.2022.30>

five miles of a pharmacy, pharmacists are one of the most convenient settings for healthcare.⁴ Pharmacist-initiated PrEP offers a significant opportunity to improve HIV prevention outcomes in areas with the greatest need.⁵ Underserved communities disproportionately impacted by HIV often face "care deserts" for primary care and sexual health clinics, this population remains highly accessible through community pharmacies which serve as a critical point of contact in high-need areas.^{6,7,8} Pharmacists are well positioned to help end the HIV epidemic by 2030, given that 85% to 90% of PrEP medications are filled at community pharmacies.^{9,10} Expanded HIV testing and access to HIV prevention tools, such as PrEP, are key contributors to decreases in HIV transmission.¹¹

Preliminary Department data as of January 31, 2026, show a 14% decrease in new HIV diagnoses in Maryland (from 784 in 2024 to 676 in 2025).¹² Expanding the HIV prevention provider base to include pharmacists is a strategy to help maintain this momentum and meet the national "Ending the HIV Epidemic" 2030 goals. As of February 2026, 20 states have laws granting pharmacists authority to prescribe and/or dispense PrEP, either as standalone expanded scope or in collaboration with other clinicians.¹³

While HB 1114 grants pharmacists the authority to prescribe PrEP, the Department notes that the bill does not authorize pharmacists to perform HIV tests to confirm a patient's HIV-negative status. The current clinical standards require an HIV test within one week before starting PrEP. HIV point-of-care testing would be the most feasible method, as it provides rapid results and supports the immediate initiation of PrEP by pharmacists.

⁴ Berenbrok, L. A., Tang, S., Gabriel, N., Guo, J., Sharareh, N., Patel, N., Dickson, S., & Hernandez, I. (2022). Access to community pharmacies: A nationwide geographic information systems cross-sectional analysis. *Journal of the American Pharmacists Association*, 62(6). <https://doi.org/10.1016/j.japh.2022.07.003>

⁵ Zhao, A., Dangerfield, D. T., 2nd, Nunn, A., Patel, R., Farley, J. E., Ugoji, C. C., & Dean, L. T. (2022). Pharmacy-Based Interventions to Increase Use of HIV Pre-exposure Prophylaxis in the United States: A Scoping Review. *AIDS and behavior*, 26(5), 1377–1392. <https://doi.org/10.1007/s10461-021-03494-4>

⁶ Crawford, N. D., Harrington, K. R. V., Chandra, C., Alohan, D. I., Quamina, A., Beck, O., & Young, H. N. (2024). Feasibility of reaching populations at high risk for HIV in community pharmacies. *Journal of the American Pharmacists Association : JAPhA*, 64(6), 102239. <https://doi.org/10.1016/j.japh.2024.102239>

⁷ Gaskin, D. J., Dinwiddie, G. Y., Chan, K. S., & McCleary, R. R. (2012). Residential segregation and the availability of primary care physicians. *Health services research*, 47(6), 2353–2376. <https://doi.org/10.1111/j.1475-6773.2012.01417.x>

⁸ Harrington, K. R. V., Hamilton, C., Alohan, D. I., Hudson, A., Young, H. N., & Crawford, N. D. (2025). The PrEP Pharmacy Reach Study: Protocol for the Creation of Maps to Visualize the Impact of Expanding Access to HIV Prevention Services Through Pharmacies. *JMIR public health and surveillance*, 11, e75077. <https://doi.org/10.2196/75077>

⁹ Highleyman, L. (2018). PrEP use growing in US, but not reaching all those in need. Aidsmap.com. <https://www.aidsmap.com/news/mar-2018/prep-use-growing-us-not-reaching-all-those-need>

¹⁰ HIV.gov. Overview: what is ending the HIV epidemic in the U.S.? Updated December 2023. <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>

¹¹ HIV/AIDS NATIONAL STRATEGY. (2021). The White House. <https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf>

¹² Core Indicators for Monitoring the Ending the HIV Epidemic Initiative (preliminary data): National HIV Surveillance System Data Reported Through September 2025. (2025). HIV Surveillance Data Tables 2025, 6(3). Cdc.gov. <https://stacks.cdc.gov/view/cdc/252554#tabs-2>

¹³ Pharmacists' Authority to Initiate PrEP and PEP and Engage in Collaborative Practice Agreements. (2024, August 19). NASTAD. <https://nastad.org/resources/pharmacists-authority-engage-collaborative-practice-agreements-and-initiate-prep-pep-and>

About Maryland Medicaid Impact

Under the Maryland Medicaid program, the Department covers both PrEP and PEP through the managed care organizations (MCOs) and the Fee-for-Service (FFS) program. While the FFS Program does not require prior authorization for HIV prevention drugs, some MCOs currently have prior authorization requirements for PrEP. PEP drug regimens are not subject to prior authorization requirements.

Both the MCOs and the FFS prescription drug program have copays for drugs: \$1 for generic/preferred drugs and \$3 for brand-name/nonpreferred drugs. Copays are automatically waived for (i) Family planning services and supplies; (ii) Individuals younger than 21 years old; (iii) Pregnant women; (iv) Institutionalized individuals who are inpatients in long-term care facilities or other institutions; and (v) Emergency services. In calendar year (CY) 2022, co-pays related to HIV/AIDs drugs amounted to \$4,906 in the FFS program and \$140,914 in HealthChoice. These co-pays are considered revenue for the Department.

In CY 2025, the Department collected \$4,439,799 in copays for all FFS drugs. The Department advises that eliminating copays for PrEP and PEP would require the elimination of copays for all drugs to ensure the Department remains compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), resulting in a significant fiscal impact. Compliance with MHPAEA includes an assessment of financial requirements, such as copays, placed on medical surgical (M/S) benefits in comparison with those in place for mental health and substance use disorder (MH/SUD) benefits. Historically, certain MCOs elected to waive some or all co-pays as a supplemental benefit paid for from their own profits. CMS determined that this created a parity violation where other mental health and substance use disorder drugs were subject to copays.¹⁴

The Department further notes that §71120 of H.R. 1, the One Big Beautiful Bill Act of 2025, requires states to impose cost sharing on services provided to the Affordable Care Act (ACA) Expansion Adults. Beginning October 1, 2028, states must impose cost sharing on ACA adults that cannot exceed \$35 for any care, item, or service, and aggregate out-of-pocket costs for a family cannot exceed 5% of the family's income. While the State may have discretion in determining which services will require cost-sharing, future CMS guidance may dictate that ACA adults pay cost-sharing for all services, including drugs.

If you would like to discuss this further, please do not hesitate to contact Meghan Lynch, Director of Governmental Affairs at meghan.lynch@maryland.gov.

Sincerely,



Meena Seshamani, M.D., Ph.D.
Secretary of Health

¹⁴ See page 14 for additional information.

<https://health.maryland.gov/mmcp/Documents/Parity/2025/2025%20Maryland%20Medicaid%20MHPAEA%20Report.pdf>