HOUSE BILL 534

C3 5lr1457

By: **Delegate Morhaim**
Introduced and read first time: February 11, 2015
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Coverage of Brand Name Prescription Drugs for Mental Health Treatment

FOR the purpose of requiring certain health insurance entities to establish and implement a certain procedure that provides for coverage of certain prescription drugs under certain circumstances; prohibiting certain health insurance entities from imposing certain cost–sharing requirements on coverage for certain brand name prescription drugs that are less favorable to a member than the cost–sharing requirements that apply to coverage for certain equivalent generic prescription drugs; prohibiting certain health insurance entities from requiring a member to pay a certain difference in cost between certain prescription drugs under certain circumstances; providing for the application of this Act; and generally relating to health insurance coverage of brand name prescription drugs for mental health treatment.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–831
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

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

Article – Insurance

15–831.

(a) (1) In this section the following words have the meanings indicated.

(2) "Authorized prescriber" has the meaning stated in § 12–101 of the Health Occupations Article.

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

(3) "Formulary" means a list of prescription drugs or devices that are covered by an entity subject to this section.

(4) (i) "Member" means an individual entitled to health care benefits for prescription drugs or devices under a policy issued or delivered in the State by an entity subject to this section.

(ii) "Member" includes a subscriber.

(b) (1) This section applies to:

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

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

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

(3) This section does not apply to a managed care organization as defined in § 15–101 of the Health – General Article.

(c) Each entity subject to this section that limits its coverage of prescription drugs or devices to those in a formulary shall establish and implement a procedure by which a member may receive a prescription drug or device that is not in the entity's formulary in accordance with this section.

(d) The procedure shall provide for coverage for a prescription drug or device that is not in the formulary if, in the judgment of the authorized prescriber:

(1) there is no equivalent prescription drug or device in the entity's formulary; or

(2) an equivalent prescription drug or device in the entity's formulary:

(i) has been ineffective in treating the disease or condition of the member; or

(ii) has caused or is likely to cause an adverse reaction or other harm to the member.

(E) (1) THIS SUBSECTION APPLIES TO A PRESCRIPTION DRUG THAT IS PRESCRIBED FOR THE TREATMENT OF A MENTAL HEALTH DISEASE OR CONDITION.

(2) AN ENTITY SUBJECT TO THIS SECTION THAT LIMITS ITS COVERAGE OF A PRESCRIPTION DRUG TO A GENERIC DRUG SHALL ESTABLISH AND IMPLEMENT A PROCEDURE BY WHICH A MEMBER MAY RECEIVE AN EQUIVALENT BRAND NAME PRESCRIPTION DRUG IN ACCORDANCE WITH THIS SUBSECTION.

(3) THE PROCEDURE SHALL PROVIDE FOR COVERAGE OF THE BRAND NAME PRESCRIPTION DRUG IF THE EQUIVALENT GENERIC DRUG:

(I) HAS BEEN INEFFECTIVE IN TREATING THE DISEASE OR CONDITION OF THE MEMBER; OR

(II) HAS CAUSED OR IS LIKELY TO CAUSE AN ADVERSE REACTION OR OTHER HARM TO THE MEMBER.

(4) AN ENTITY SUBJECT TO THIS SECTION MAY NOT:

(I) IMPOSE DOLLAR LIMITS, COPAYMENTS, DEDUCTIBLES, OR COINSURANCE REQUIREMENTS ON COVERAGE FOR BRAND NAME PRESCRIPTION DRUGS REQUIRED UNDER THIS SUBSECTION THAT ARE LESS FAVORABLE TO A MEMBER THAN THE DOLLAR LIMITS, COPAYMENTS, DEDUCTIBLES, OR COINSURANCE REQUIREMENTS THAT APPLY TO COVERAGE FOR THE EQUIVALENT GENERIC PRESCRIPTION DRUG; OR

(II) REQUIRE THE MEMBER TO PAY THE DIFFERENCE IN COST BETWEEN A BRAND NAME PRESCRIPTION DRUG FOR WHICH COVERAGE IS REQUIRED UNDER THIS SUBSECTION AND THE LOWER COST EQUIVALENT GENERIC PRESCRIPTION DRUG.

[(e)**] (F)** A decision by an entity subject to this section not to provide access to or coverage of a prescription drug or device in accordance with this section constitutes an adverse decision as defined under Subtitle 10A of this title if the decision is based on a finding that the proposed drug or device is not medically necessary, appropriate, or efficient.

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 October 1, 2015.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2015.