HB 584

Department of Human Resource Management; employee health insurance; pharmacy benefits; reverse auction process. Directs the Department of Human Resource Management to utilize a reverse auction process to award pharmacy benefit manager contracts for pharmacy benefits offered under the state employee health insurance plan.

HB 943

Health insurance; retail community pharmacies. Requires a carrier to administer its health benefit plans in a manner consistent with certain requirements and to include such requirements in its provider contracts addressing the provision of pharmacy benefits management. The bill provides that (i) a covered individual is permitted to fill any mail order-covered prescription, at the covered individual's option, at any mail order pharmacy or network participating retail community pharmacy under certain conditions; (ii) the carrier or pharmacy benefits manager is prohibited from imposing a differential copayment, additional fee, rebate, bonus, or other condition on any covered individual who elects to fill his prescription at an in-network retail community pharmacy that is not similarly imposed on covered individuals electing to fill a prescription from a mail order pharmacy; and (iii) the pharmacy benefits manager is required to expressly disclose to the carrier in the contract if the pharmacy benefits manager retains all or a greater portion of a drug manufacturer's rebate amount or any additional direct or indirect remuneration from any third party for drugs dispensed through the pharmacy benefits manager-owned mail

order pharmacy than the pharmacy benefits manager does for drugs dispensed through a retail community pharmacy. The bill also removes the exemption for a self-insured or self-funded employee welfare benefit plan under provisions regulating pharmacy benefits managers.

SB 376

Prescription Drug Affordability Board; established; drug cost affordability review. Establishes the Prescription Drug Affordability Review Board for the purpose of protecting state residents, state and local governments, commercial health plans, health care providers, pharmacies licensed in the Commonwealth, and other stakeholders within the health care system from the high costs of prescription drug products.

HB 591

Secretary of Health and Human Resources; plan to consolidate state agency prescription drug purchasing and reimbursement programs; report. Directs the Secretary of Health and Human Resources to develop a plan to consolidate state agency prescription drug purchasing and reimbursement programs to increase efficiency in prescription drug purchasing and reduce spending on prescription drugs. The bill directs the Secretary to provide to the Governor and General Assembly an interim report on the development of the plan to consolidate state agency prescription drug purchasing and reimbursement programs by November 1, 2022, and a final report on the plan by

November 1, 2023.

HB 1075

Health care provider panels; vertically integrated Health care provider panels; vertically integrated carriers; reimbursements to providers. Requires any vertically integrated carrier, upon written request, to offer participation in each requested provider panel or network established for each of the vertically integrated carrier's policies, products, and plans, including all policies, products, and plans offered to individuals, employers, and enrollees in government benefit programs, to the requesting provider under the same terms and conditions that apply to providers under common control with the vertically integrated carrier. The measure requires that the offered participation (i) be without any adverse tiering or other financial incentives that may discourage enrollees from utilizing the services of the provider, (ii) include all sites and services offered by the provider, and (iii) take into account the different characteristics of different providers with regard to the range, nature, cost, and complexity of services offered. The measure prohibits an officer or director of a vertically integrated carrier from simultaneously serving as an officer or director of an entity that owns, operates, manages, or controls an acute care hospital located, in whole or in part, in the Commonwealth. The measure defines "vertically integrated carrier" as a health insurer or other carrier that owns an interest in, is owned by, or is under common ownership or control with an acute care hospital facility, excluding an entity that is under the ultimate control of or under common control with a public hospital. If a provider panel contract between a provider and a carrier, or

other entity that provides hospital, physician or other health care services to a carrier, includes provisions that require a provider, as a condition of participating in one of the carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that carrier or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more such other provider panels at the time the contract is executed.

HB 478

Secretary of Health and Human Resources; wholesale prescription drug importation program. Directs the Secretary of Health and Human Resources (the Secretary) to establish a wholesale prescription drug importation program that complies with the requirements of federal law and to report annually by October 1 to the Governor and the Chairmen of the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Finance and Appropriations and Education and Health on the wholesale prescription drug importation program. The bill also requires the Secretary to (i) convene a workgroup composed of relevant stakeholders to develop a plan for implementation of the wholesale prescription drug importation program and report the plan to the Governor and the Chairmen of the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Finance and Appropriations and Education and Health by December 1, 2022, and (ii) seek such federal approvals, waivers, exemptions, or agreements as may be necessary to enable all covered entities enrolled in or eligible for the federal 340B Drug Pricing Program to participate in the wholesale prescription drug importation

program to the greatest extent possible without jeopardizing their eligibility for the 340B Drug Pricing Program by July 1, 2023.

HB 240

State health plan; insulin discount program; health insurance; cost sharing for insulin. Requires the state health plan established by the Department of Human Resource Management to offer an insulin discount program that allows individuals other than state employees to purchase insulin at a discounted, post-rebate price. The bill requires the insulin discount program to (i) allow a participant to purchase insulin at a discounted, post-rebate price; (ii) provide a participant with a card or electronic document that identifies the participant as eligible for the discount; (iii) provide a participant with information about pharmacies that will honor the discount; and (iv) provide a participant with instructions to pursue a reimbursement of the purchase price from the participant’s carrier. The bill requires the discount program to charge a price for insulin that allows the program to retain only enough of any rebate for the insulin to make the state risk pool whole for providing discounted insulin to participants.

Additionally, the bill requires health plans offered by a carrier to set the cost-sharing payment that a covered person is required to pay for at least one prescription insulin drug in each therapy category at an amount that does not exceed $30 per 30-day supply of the prescription insulin drug unless the health plan (a) covers at least one prescription insulin drug for the treatment of diabetes in each therapy category under the lowest tier of drugs and does not require cost sharing

other than the cost sharing payment before the plan will cover insulin at the lowest tier or (b) guarantees that a covered person is not required to pay more out of pocket for a prescription insulin drug than the covered person would pay to obtain the prescription insulin drug through the insulin discount program and caps the total amount that a covered person is required to pay for at least one prescription insulin drug in each therapy category at an amount not to exceed $100 per 30-day supply of the prescription insulin drug. Under current law, a health plan is required to set the cost-sharing payment that a covered person is required to pay for a covered prescription insulin drug at an amount that does not exceed $50 per 30-day supply of the prescription insulin drug, regardless of the amount or type of insulin needed to fill the covered person's prescription.

The bill also allows a health plan that provides coverage of a prescription insulin drug with the cost-sharing limits established in the bill to condition the cost-sharing limits on (1) the covered person's participation in a wellness-related activities for diabetes, (2) purchasing the prescription insulin drug at an in-network pharmacy, or (3) choosing a prescription insulin drug from the lowest ties of the health plan' s formulary.

HB 1602 (see companion bill SB 1418)

State plan for medical assistance services; telemedicine; in-state presence. Establishes that health care providers are not required to maintain a physical presence in the Commonwealth to maintain eligibility to enroll as a Medicaid provider.

Additionally, the bill establishes that telemedicine services provider groups with health care providers duly licensed by the Commonwealth are not required to maintain an in-state service address to maintain eligibility to enroll as a Medicaid vendor or Medicaid provider group.

HB 1879

Managed care health insurance plan licensees; network adequacy for mental health care services. Requires each managed care health insurance plan licensee (licensee) to (i) provide a sufficient number and mix of services, specialists, and practice sites to meet covered persons' mental health care needs; (ii) ensure that covered persons have telephone access 24 hours a day, seven days a week, to responsible and knowledgeable mental health care practitioners capable of assessing the covered persons' conditions and, as necessary, providing for appropriate services; and (iii) incorporate strategies into its access procedures to facilitate utilization of the licensee's mental health care services by covered persons with physical, mental, language, or cultural barriers. The bill requires a managed care health insurance plan licensee to cover out-of-network mental health care services to a covered person if (a) the licensee does not have a mental health care provider within its network capable of providing mental health care services to the covered person; (b) the majority of the managed care health insurance plan licensee's mental health care providers within 25 miles of a covered person or, if appropriate for the covered person, available via telemedicine who have experience treating the general age group of a covered person are no longer accepting new patients or have wait-lists to receive care; or (c) the managed care health insurance plan licensee does not have a

mental health care provider within 25 miles of a covered person or, if appropriate for the covered person, available via telemedicine who (1) has experience or expertise in treating patients who share the emotionally distressing experiences, defined in the bill, or demographics of the covered person seeking care and (2) is capable of providing care within the next 31 days. The bill provides that a licensee may require certain verification that the mental health care services are related to an emotionally distressing experience but is prohibited from requiring proof of a criminal proceeding.

HB 2190 (see companion bill SB 1270)

Department of Medical Assistance Services; data collection and analysis; claims submitted to managed care organizations; report. Requires the Department of Medical Assistance Services to collect data for each fiscal year from fiscal year 2018 through fiscal year 2022 regarding (i) the number and percentage of claims submitted to managed care organizations that were denied and the reasons for such denials and (ii) the number and percentage of claims submitted to managed care organizations that required resubmission prior to payment and the reasons for such resubmissions and to examine such data and identify barriers that providers encounter when accepting and treating patients enrolled in the state plan for medical assistance services. Under the bill, the Department shall report such data and analysis by November 1, 2023, to the Joint Commission on Health Care and the Joint Subcommittee for Health and Human Resources Oversight.