

Department of Legislative Services
Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1461
Health

(Delegate Taveras, *et al.*)

Health Insurance - Coverage for Specialty Drugs - Rheumatologic Conditions

This bill prohibits certain insurers, nonprofit health service plans, and health maintenance organizations (collectively carriers), including those that provide prescription drug coverage through a pharmacy benefits manager (PBM), from excluding coverage for a covered specialty drug for the treatment of rheumatologic conditions under specified circumstances. **The bill takes effect January 1, 2027, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) in FY 2027 only from the \$125 rate and form filing fee; any additional workload for MIA can be absorbed with existing budgeted resources. No impact on the State Employee and Retiree Health and Welfare Benefits Program.

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: A carrier, including one that provides prescription drug coverage through a PBM, may not exclude coverage for a covered specialty drug administered or dispensed by a provider if the carrier determines that (1) the provider is an in-network provider of covered rheumatology services and complies with State regulations for the administering and dispensing of specialty drugs and (2) the drug is auto-injected, an oral targeted immune

modulator, or an oral medication that requires complex dosing based on clinical presentation or is used concomitantly with other infusion therapies. Exceptions carved out for specialty drugs under Chapters 728 and 729 of 2025 also apply to specialty drugs for the treatment of rheumatologic conditions.

Current Law:

Specialty Drugs

“Specialty drug” means a prescription drug that (1) is prescribed for an individual with a complex, chronic, or rare medical condition; (2) costs \$600 or more for up to a 30-day supply; (3) is not typically stocked at retail pharmacies; and (4) requires either a difficult or unusual process of delivering the drug to the patient or enhanced patient education, management, or support before or after administration of the drug. “Specialty drug” does not include a prescription drug prescribed to treat diabetes, HIV, or AIDS; it does include a prescription drug prescribed to treat multiple sclerosis, hepatitis C, rheumatoid arthritis, cystic fibrosis, hemophilia, or multiple myeloma.

Chapters 728 and 729 prohibit certain carriers, including those that provide prescription drug coverage through a PBM, from excluding coverage for a covered specialty drug administered or dispensed by a provider if the carrier determines that (1) the provider is an in-network provider of covered oncology services and complies with State regulations for the administering and dispensing of specialty drugs and (2) the drug is auto-injected, an oral targeted immune modulator, or an oral medication that requires complex dosing based on clinical presentation or is used concomitantly with other infusion or radiation therapies.

Carriers

A carrier may require a subscriber, member, or beneficiary to obtain a specialty drug (with an exception for specialty drugs under Chapters 728 and 729) through a specific pharmacy, including a pharmacy participating in the carrier’s provider network, if the carrier determines that the pharmacy meets its performance standards and accepts its network reimbursement fees.

The reimbursement rate for a covered specialty drug must be agreed to by the carrier and the covered, in-network provider and billed at a nonhospital level of care or place of service.

A carrier may refuse to authorize or approve or may deny coverage of a covered specialty drug administered or dispensed by a provider if administering or dispensing the drug fails to satisfy medical necessity criteria.

Pharmacy Benefits Managers

A PBM is a business that administers and manages prescription drug benefit plans. A PBM must register with MIA prior to providing pharmacy benefits management services.

A PBM that provides pharmacy benefits management services on behalf of a carrier may not require that a beneficiary use a specific pharmacy or entity to fill a prescription if the PBM (or a corporate affiliate) has an ownership interest in the pharmacy or entity or vice versa. A PBM may require a beneficiary to use a specific pharmacy or entity for a specialty drug (with an exception for specialty drugs under Chapters 728 and 729).

A PBM that provides pharmacy benefits management services on behalf of a carrier may not reimburse a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less than the PBM reimburses itself or an affiliate for providing the same product or service. This prohibition does not apply to reimbursement for specialty drugs (with an exception for specialty drugs under Chapters 728 and 729), mail order drugs, or to a chain pharmacy with more than 15 stores or a pharmacist who is an employee of the chain pharmacy.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: None.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Insurance Administration; Department of Legislative Services

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