

HOUSE BILL 675

J5, J4

2lr0887
CF 2lr2810

By: **Delegates Hartman, Boteler, Chisholm, Hornberger, Krebs, Mangione,
McComas, Otto, Parrott, Reilly, Rose, Szeliga, and Thiam**

Introduced and read first time: January 31, 2022

Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Changes to Coverage, Benefits, and Drug Formularies –**
3 **Timing**

4 FOR the purpose of prohibiting certain insurers, nonprofit health service plans, and health
5 maintenance organizations from making changes to coverage, benefits, or drug
6 formularies under a health insurance policy or contract during the term of the health
7 insurance policy or contract; authorizing certain insurers, nonprofit health service
8 plans, and health maintenance organizations to make certain changes to coverage,
9 benefits, and drug formularies on renewal of a health insurance policy or contract;
10 and generally relating to health insurance and changes to coverage, benefits, and
11 drug formularies.

12 BY adding to
13 Article – Insurance
14 Section 15–146
15 Annotated Code of Maryland
16 (2017 Replacement Volume and 2021 Supplement)

17 BY repealing and reenacting, with amendments,
18 Article – Insurance
19 Section 15–831
20 Annotated Code of Maryland
21 (2017 Replacement Volume and 2021 Supplement)

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

24 **Article – Insurance**

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 15-146.

2 (A) THIS SECTION APPLIES TO:

3 (1) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT
4 PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS
5 ON AN EXPENSE-INCURRED BASIS UNDER HEALTH INSURANCE POLICIES THAT ARE
6 ISSUED OR DELIVERED IN THE STATE;

7 (2) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE
8 HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS UNDER
9 CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

10 (3) INSURERS, NONPROFIT HEALTH SERVICE PLANS, AND HEALTH
11 MAINTENANCE ORGANIZATIONS THAT PROVIDE COVERAGE FOR PRESCRIPTION
12 DRUGS THROUGH A PHARMACY BENEFITS MANAGER.

13 (B) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, AN ENTITY
14 SUBJECT TO THIS SECTION:

15 (1) MAY NOT CHANGE THE COVERAGE OF SERVICES OR BENEFITS
16 PROVIDED UNDER A HEALTH INSURANCE POLICY OR CONTRACT DURING THE TERM
17 OF THE POLICY OR CONTRACT; AND

18 (2) MAY CHANGE THE COVERAGE OF SERVICES OR BENEFITS
19 PROVIDED UNDER A HEALTH INSURANCE POLICY OR CONTRACT ON RENEWAL OF
20 THE POLICY OR CONTRACT.

21 15-831.

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

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

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

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

30 (ii) "Member" includes a subscriber.

31 (b) (1) This section applies to:

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

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

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

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

12 (c) Each entity subject to this section that limits its coverage of prescription drugs
13 or devices to those in a formulary shall establish and implement a procedure by which a
14 member may:

15 (1) receive a prescription drug or device that is not in the entity's formulary
16 or has been removed from the entity's formulary in accordance with this section; or

17 (2) continue the same cost sharing requirements if the entity has moved
18 the prescription drug or device to a higher deductible, copayment, or coinsurance tier.

19 (d) The procedure shall provide for coverage for a prescription drug or device in
20 accordance with subsection (c) of this section if, in the judgment of the authorized
21 prescriber:

22 (1) there is no equivalent prescription drug or device in the entity's
23 formulary in a lower tier;

24 (2) an equivalent prescription drug or device in the entity's formulary in a
25 lower tier:

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

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

30 (3) for a contraceptive prescription drug or device, the prescription drug or
31 device that is not on the formulary is medically necessary for the member to adhere to the
32 appropriate use of the prescription drug or device.

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

6 (f) **(1) AN ENTITY SUBJECT TO THIS SECTION:**

7 **(I) MAY NOT REMOVE A DRUG FROM ITS FORMULARY OR MOVE**
8 **A PRESCRIPTION DRUG OR DEVICE TO A BENEFIT TIER THAT REQUIRES A MEMBER**
9 **TO PAY A HIGHER DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT FOR THE**
10 **PRESCRIPTION DRUG OR DEVICE DURING THE TERM OF A HEALTH INSURANCE**
11 **POLICY OR CONTRACT; AND**

12 **(II) MAY REMOVE A DRUG FROM ITS FORMULARY OR MOVE A**
13 **PRESCRIPTION DRUG OR DEVICE TO A BENEFIT TIER THAT REQUIRES A MEMBER TO**
14 **PAY A HIGHER DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT FOR THE**
15 **PRESCRIPTION DRUG OR DEVICE ON RENEWAL OF A HEALTH INSURANCE POLICY OR**
16 **CONTRACT.**

17 **(2) [An] ON RENEWAL OF A HEALTH INSURANCE POLICY OR**
18 **CONTRACT, AN** entity subject to this section that removes a drug from its formulary or
19 moves a prescription drug or device to a benefit tier that requires a member to pay a higher
20 deductible, copayment, or coinsurance amount for the prescription drug or device shall
21 provide a member who is currently on the prescription drug or device and the member's
22 health care provider with:

23 **[(1)] (I)** notice of the change at least 30 days before the change is
24 implemented; and

25 **[(2)] (II)** in the notice required under item **[(1)] (I)** of this **[subsection]**
26 **PARAGRAPH**, the process for requesting an exemption through the procedure adopted in
27 accordance with this section.

28 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all
29 policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or
30 after January 1, 2023.

31 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
32 January 1, 2023.