This bill prohibits an insurer, nonprofit health service plan, or health maintenance organization (collectively known as carriers) from changing the coverage of services or benefits provided under a health insurance policy or contract during the term of the policy or contract. A carrier may change the coverage of services or benefits on renewal of the policy or contract. A carrier that provides coverage for prescription drugs (including through a pharmacy benefits manager) may not remove a drug from its formulary or move a prescription drug or device to a benefit tier that requires a higher deductible, copayment, or coinsurance during the term of the policy or contract; a carrier may do so on renewal. The bill takes effect January 1, 2023, 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 increase in special fund revenues for the Maryland Insurance Administration in FY 2023 only from the $125 rate and form filing fee; review of filings can be handled with existing budgeted resources. No impact on the State Employee and Retiree Health and Welfare Benefits Program, as discussed below.

Local Effect: Potential increase in health care expenditures for local governments that purchase fully insured health benefit plans. Revenues are not affected.

Small Business Effect: Minimal.
Analysis

**Current Law:** Under the federal Patient Protection and Affordable Care Act, notice of material modifications (which includes any change to benefits that takes place other than at renewal of coverage) to a health benefit plan must be provided to participants at least 60 days in advance of the date of the change. For plans subject to the federal Employee Retirement Income Security Act of 1974, notice of any material changes that reduce benefits or services must be provided to plan administrators to inform plan participants of these changes no later than 60 days after the material reduction was adopted.

Chapters 503 and 504 of 2019, among other things, require a carrier that removes a drug from its formulary or moves a drug to a benefit tier with a higher deductible, copayment, or coinsurance amount to provide a member and the member’s health care provider with (1) notice at least 30 days before the change is implemented and (2) included in the notice, the process for requesting a specified exemption.

The Acts also require that each carrier’s procedure authorize a member to continue the same cost-sharing requirements if the carrier has moved the prescription drug or device to a higher deductible, copayment, or coinsurance tier. A decision of a carrier not to provide access to or coverage of a prescription drug or device in accordance with these requirements constitutes an adverse decision if the decision is based on a finding that the proposed drug or device is not medically necessary, appropriate, or efficient.

**State Fiscal Effect:** The Department of Budget and Management advises that the State Employee and Retiree Health and Welfare Benefits Program only makes changes at the policy anniversary or renewal date (January 1) unless a mid-year change is required under federal law. Thus, there is no impact on the program.

**Additional Comments:** The bill’s prohibition on a carrier changing the coverage of services or benefits during the term of a health insurance policy or contract may prevent a carrier from adding or improving benefits provided during the plan year.

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**Additional Information**

**Prior Introductions:** None.

**Designated Cross File:** HB 675 (Delegate Hartman, *et al.*) - Health and Government Operations.