HOUSE BILL 1440

J5 6lr3133
CF SB 837

By: **Delegates Woorman, Kaufman, and Martinez**
Introduced and read first time: February 13, 2026
Assigned to: Health

A BILL ENTITLED

AN ACT concerning

Maryland Medical Assistance Program and Health Insurance – Coverage and Utilization Review – Drugs Reviewed by the Prescription Drug Affordability Board

FOR the purpose of prohibiting a managed care organization and certain insurers, nonprofit health service plans, and health maintenance organizations from requiring a prior authorization or step therapy or fail–first protocol under certain circumstances for prescription drugs that have been reviewed by the Prescription Drug Affordability Board; prohibiting a managed care organization and certain insurers, nonprofit health service plans, and health maintenance organizations from limiting, restricting, or excluding coverage of prescription drugs that have been reviewed by the Board under certain circumstances; and generally relating to coverage and utilization review requirements for drugs reviewed by the Prescription Drug Affordability Board.

BY adding to
Article – Health – General
Section 15–102.3(p) and 15–103(b)(34) and (35)
Annotated Code of Maryland
(2023 Replacement Volume and 2025 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–142(a) and (b)
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

BY adding to
Article – Insurance
Section 15–142(f)
Annotated Code of Maryland

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

(2017 Replacement Volume and 2025 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–142(f), 15–831, and 15–854
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

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

Article – Health – General

15–102.3.

(P) THE PROVISIONS OF § 15–142(F) OF THE INSURANCE ARTICLE APPLY TO MANAGED CARE ORGANIZATIONS.

15–103.

(b) **(34) A MANAGED CARE ORGANIZATION MAY NOT REQUIRE A PRIOR AUTHORIZATION FOR A PRESCRIPTION DRUG THAT HAS BEEN REVIEWED BY THE PRESCRIPTION DRUG AFFORDABILITY BOARD IF THE BOARD:**

(I) HAS NOT MADE A DETERMINATION THAT THE PRESCRIPTION DRUG HAS LED OR WILL LEAD TO AN AFFORDABILITY CHALLENGE UNDER § 21–2C–09 OF THIS ARTICLE;

(II) HAS MADE A POLICY RECOMMENDATION RELATING TO THE DRUG TO THE GENERAL ASSEMBLY UNDER § 21–2C–09 OF THIS ARTICLE; OR

(III) HAS SET AN UPPER PAYMENT LIMIT FOR THE DRUG UNDER § 21–2C–14 OF THIS ARTICLE.

(35) (I) IN THIS PARAGRAPH, "LIMIT, RESTRICT, OR EXCLUDE" INCLUDES:

1. LIMITING OR REDUCING THE MAXIMUM COVERAGE OF PRESCRIPTION DRUG BENEFITS;

2. INCREASING THE COST SHARING FOR A COVERED PRESCRIPTION DRUG;

3. MOVING A PRESCRIPTION DRUG TO A MORE RESTRICTIVE TIER IF THE MANAGED CARE ORGANIZATION USES A FORMULARY WITH TIERS; AND

4. REMOVING A PRESCRIPTION DRUG FROM A FORMULARY, UNLESS:

A. THE U.S. FOOD AND DRUG ADMINISTRATION HAS ISSUED A STATEMENT ABOUT THE DRUG THAT CALLS INTO QUESTION THE CLINICAL SAFETY OF THE DRUG; OR

B. THE MANUFACTURER OF THE DRUG HAS NOTIFIED THE U.S. FOOD AND DRUG ADMINISTRATION OF A MANUFACTURING DISCONTINUANCE OR POTENTIAL DISCONTINUANCE AS REQUIRED UNDER § 506C OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(II) A MANAGED CARE ORGANIZATION MAY NOT LIMIT, RESTRICT, OR EXCLUDE COVERAGE OF A PRESCRIPTION DRUG ON THE MANAGED CARE ORGANIZATION'S FORMULARY IF THE PRESCRIPTION DRUG HAS BEEN REVIEWED BY THE PRESCRIPTION DRUG AFFORDABILITY BOARD AND THE BOARD:

1. HAS NOT MADE A DETERMINATION THAT THE PRESCRIPTION DRUG HAS LED OR WILL LEAD TO AN AFFORDABILITY CHALLENGE UNDER § 21–2C–09 OF THIS ARTICLE;

2. HAS MADE A POLICY RECOMMENDATION RELATING TO THE DRUG TO THE GENERAL ASSEMBLY UNDER § 21–2C–09 OF THIS ARTICLE; OR

3. HAS SET AN UPPER PAYMENT LIMIT FOR THE DRUG UNDER § 21–2C–14 OF THIS ARTICLE.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

15–142.

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

(2) "Step therapy drug" means a prescription drug or sequence of prescription drugs required to be used under a step therapy or fail–first protocol.

(3) "Step therapy exception request" means a request to override a step therapy or fail–first protocol.

(4) (i) "Step therapy or fail–first protocol" means a protocol established by an insurer, a nonprofit health service plan, or a health maintenance organization that requires a prescription drug or sequence of prescription drugs to be used by an insured or an enrollee before a prescription drug ordered by a prescriber for the insured or the enrollee is covered.

(ii) "Step therapy or fail–first protocol" includes a protocol that meets the definition under subparagraph (i) of this paragraph regardless of the name, label, or terminology used by the insurer, nonprofit health service plan, or health maintenance organization to identify the protocol.

(5) "Supporting medical information" means:

(i) a paid claim from an entity subject to this section for an insured or an enrollee;

(ii) a pharmacy record that documents that a prescription has been filled and delivered to an insured or an enrollee, or a representative of an insured or an enrollee; or

(iii) other information mutually agreed on by an entity subject to this section and the prescriber of an insured or an enrollee.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

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

(F) AN ENTITY SUBJECT TO THIS SECTION MAY NOT IMPOSE A STEP THERAPY OR FAIL–FIRST PROTOCOL ON AN INSURED OR AN ENROLLEE FOR A PRESCRIPTION DRUG THAT HAS BEEN REVIEWED BY THE PRESCRIPTION DRUG AFFORDABILITY BOARD IF THE BOARD:

(1) HAS NOT MADE A DETERMINATION THAT THE PRESCRIPTION DRUG HAS LED OR WILL LEAD TO AN AFFORDABILITY CHALLENGE UNDER § 21–2C–09 OF THE HEALTH – GENERAL ARTICLE;

(2) HAS MADE A POLICY RECOMMENDATION RELATING TO THE DRUG TO THE GENERAL ASSEMBLY UNDER § 21–2C–09 OF THE HEALTH – GENERAL ARTICLE; OR

(3) HAS SET AN UPPER PAYMENT LIMIT FOR THE DRUG UNDER § 21–2C–14 OF THE HEALTH – GENERAL ARTICLE.

[(f)**] (G)** (1) An entity subject to this section shall establish a process for requesting an exception to a step therapy or fail–first protocol that is:

(i) clearly described, including the specific information and documentation, if needed, that must be submitted by the prescriber to be considered a complete step therapy exception request;

(ii) easily accessible to the prescriber; and

(iii) posted on the entity's website.

(2) A step therapy exception request shall be granted if, based on the professional judgment of the prescriber and any information and documentation required under paragraph (1)(i) of this subsection:

(i) the step therapy drug is contraindicated or will likely cause an adverse reaction to the insured or enrollee;

(ii) the step therapy drug is expected to be ineffective based on the known clinical characteristics of the insured or enrollee and the known characteristics of the prescription drug regimen;

(iii) the insured or enrollee is stable on a prescription drug prescribed for the medical condition under consideration while covered under the policy or contract of the entity or under a previous source of coverage; or

(iv) while covered under the policy or contract of the entity or a previous source of coverage, the insured or enrollee has tried a prescription drug that:

1. is in the same pharmacologic class or has the same mechanism of action as the step therapy drug; and

2. was discontinued by the prescriber due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(3) On granting a step therapy exception request, an entity subject to this section shall authorize coverage for the prescription drug ordered by the prescriber for an insured or enrollee.

(4) An enrollee or insured may appeal a step therapy exception request denial in accordance with Subtitle 10A or Subtitle 10B of this title.

(5) This subsection may not be construed to:

(i) prevent:

1. an entity subject to this section from requiring an insured or enrollee to try an AB–rated generic equivalent or interchangeable biological product before providing coverage for the equivalent branded prescription drug; or

2. a health care provider from prescribing a prescription drug that is determined to be medically appropriate; or

(ii) require an entity subject to this section to provide coverage for a prescription drug that is not covered by a policy or contract of the entity.

(6) An entity subject to this section may use an existing step therapy exception process that satisfies the requirements under this subsection.

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.

(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 individual, group, or blanket 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 individual or group 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 benefits 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:

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

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

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

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

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

(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; or

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

(e) 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.

(f) An entity subject to this section that removes a drug from its formulary or moves a prescription drug or device to a benefit tier that requires a member to pay a higher deductible, copayment, or coinsurance amount for the prescription drug or device shall provide a member who is currently on the prescription drug or device and the member's health care provider with:

(1) notice of the change at least 30 days before the change is implemented; and

(2) in the notice required under item (1) of this subsection, the process for requesting an exemption through the procedure adopted in accordance with this section.

(G) (1) IN THIS PARAGRAPH, "LIMIT, RESTRICT, OR EXCLUDE" INCLUDES:

(I) LIMITING OR REDUCING THE MAXIMUM COVERAGE OF PRESCRIPTION DRUG BENEFITS;

(II) INCREASING THE COST SHARING FOR A COVERED PRESCRIPTION DRUG;

(III) MOVING A PRESCRIPTION DRUG TO A MORE RESTRICTIVE TIER IF THE ENTITY USES A FORMULARY WITH TIERS; AND

(IV) REMOVING A PRESCRIPTION DRUG FROM A FORMULARY, UNLESS:

1. THE U.S. FOOD AND DRUG ADMINISTRATION HAS ISSUED A STATEMENT ABOUT THE DRUG THAT CALLS INTO QUESTION THE CLINICAL SAFETY OF THE DRUG; OR

2. THE MANUFACTURER OF THE DRUG HAS NOTIFIED THE U.S. FOOD AND DRUG ADMINISTRATION OF A MANUFACTURING DISCONTINUANCE OR POTENTIAL DISCONTINUANCE AS REQUIRED UNDER § 506C OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(2) AN ENTITY SUBJECT TO THIS SECTION MAY NOT LIMIT, RESTRICT, OR EXCLUDE COVERAGE OF A PRESCRIPTION DRUG ON THE ENTITY'S FORMULARY IF THE PRESCRIPTION DRUG HAS BEEN REVIEWED BY THE PRESCRIPTION DRUG AFFORDABILITY BOARD AND THE BOARD:

(I) HAS NOT MADE A DETERMINATION THAT THE PRESCRIPTION DRUG HAS LED OR WILL LEAD TO AN AFFORDABILITY CHALLENGE UNDER § 21–2C–09 OF THE HEALTH – GENERAL ARTICLE;

(II) HAS MADE A POLICY RECOMMENDATION RELATING TO THE DRUG TO THE GENERAL ASSEMBLY UNDER § 21–2C–09 OF THE HEALTH – GENERAL ARTICLE; OR

(III) HAS SET AN UPPER PAYMENT LIMIT FOR THE DRUG UNDER § 21–2C–14 OF THE HEALTH – GENERAL ARTICLE.

15–854.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs through a pharmacy benefit under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs through a pharmacy benefit under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager or that contracts with a private review agent under Subtitle 10B of this title 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.

(b) (1) (i) If an entity subject to this section requires a prior authorization for a prescription drug, the prior authorization request shall allow a health care provider to indicate whether a prescription drug is to be used to treat a chronic condition.

(ii) If a health care provider indicates that the prescription drug is to treat a chronic condition, an entity subject to this section may not request a reauthorization for a repeat prescription for the prescription drug for 1 year or for the standard course of treatment for the chronic condition being treated, whichever is less.

(2) For a prior authorization that is filed electronically, the entity shall maintain a database that will prepopulate prior authorization requests with an insured's available insurance and demographic information.

(C) AN ENTITY SUBJECT TO THIS SECTION MAY NOT REQUIRE A PRIOR AUTHORIZATION FOR A PRESCRIPTION DRUG THAT HAS BEEN REVIEWED BY THE PRESCRIPTION DRUG AFFORDABILITY BOARD IF THE BOARD:

(1) HAS NOT MADE A DETERMINATION THAT THE PRESCRIPTION DRUG HAS LED OR WILL LEAD TO AN AFFORDABILITY CHALLENGE UNDER § 21–2C–09 OF THE HEALTH – GENERAL ARTICLE;

(2) HAS MADE A POLICY RECOMMENDATION RELATING TO THE DRUG TO THE GENERAL ASSEMBLY UNDER § 21–2C–09 OF THE HEALTH – GENERAL ARTICLE; OR

(3) HAS SET AN UPPER PAYMENT LIMIT FOR THE DRUG UNDER § 21–2C–14 OF THE HEALTH – GENERAL ARTICLE.

[(c)**] (D)** (1) On receipt of information documenting a prior authorization from the insured or from the insured's health care provider, an entity subject to this section shall honor a prior authorization granted to an insured from a previous entity for at least the lesser of 90 days or the length of the course of treatment.

(2) During the time period described in paragraph (1) of this subsection, an entity may perform its own review to grant a prior authorization for the prescription drug.

[(d)**] (E)** (1) An entity subject to this section shall honor a prior authorization issued by the entity for a prescription drug and may not require a health care provider to submit a request for another prior authorization for the prescription drug:

(i) if the insured changes health benefit plans that are both covered by the same entity and the prescription drug is a covered benefit under the current health benefit plan; or

(ii) except as provided in paragraph (2) of this subsection, when the dosage for the approved prescription drug changes and the change is consistent with federal Food and Drug Administration labeled dosages.

(2) Except as provided in § 15–851 of this subtitle, an entity may require a prior authorization for a change in dosage for an opioid under this subsection.

[(e)**] (F)** (1) If an entity under this section implements a new prior authorization requirement for a prescription drug, the entity shall provide notice of the new requirement at least 60 days before the implementation of a new prior authorization requirement:

(i) in writing to any insured who is prescribed the prescription drug; and

(ii) either in writing or electronically to all contracted health care providers.

(2) The notice required under paragraph (1) of this subsection shall indicate that the insured may remain on the prescription drug at the time of reauthorization in accordance with subsection **[**(g)**] (H)** of this section.

[(f)**] (G)** (1) Except as provided in paragraph (2) of this subsection, an entity subject to this section may not require more than one prior authorization if two or more tablets of different dosage strengths of the same prescription drug are:

(i) prescribed at the same time as part of an insured's treatment plan; and

(ii) manufactured by the same manufacturer.

(2) This subsection does not prohibit an entity from requiring more than one prior authorization if the prescription is for two or more tablets of different dosage strengths of an opioid that is not an opioid partial agonist.

[(g)**] (H)** (1) An entity subject to this section may not issue an adverse decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if:

(i) the prescription drug is:

1. an immune globulin (human) as defined in 21 C.F.R. § 640.100; or

2. used for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association;

(ii) the entity previously approved a prior authorization for the prescription drug for the insured;

(iii) the insured has been treated with the prescription drug without interruption since the initial approval of the prior authorization; and

(iv) the prescriber attests that, based on the prescriber's professional judgment, the prescription drug continues to be necessary to effectively treat the insured's condition.

(2) If the prescription drug that is being requested has been removed from the formulary or has been moved to a higher deductible, copayment, or coinsurance tier, the entity shall provide the insured and insured's health care provider the information required under § 15–831 of this subtitle.

SECTION 3. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2027.

SECTION 4. AND BE IT FURTHER ENACTED, That Sections 2 and 3 of this Act shall take effect January 1, 2027.

SECTION 5. AND BE IT FURTHER ENACTED, That, except as provided in Section 4 of this Act, this Act shall take effect July 1, 2026.