

SENATE BILL 837

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6lr2083
CF 6lr3133

By: **Senators Ready and Lam**

Introduced and read first time: February 6, 2026

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

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

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

15 BY adding to

16 Article – Health – General
17 Section 15–102.3(p) and 15–103(b)(34) and (35)
18 Annotated Code of Maryland
19 (2023 Replacement Volume and 2025 Supplement)

20 BY repealing and reenacting, without amendments,

21 Article – Insurance
22 Section 15–142(a) and (b)
23 Annotated Code of Maryland
24 (2017 Replacement Volume and 2025 Supplement)

25 BY adding to

26 Article – Insurance
27 Section 15–142(f)
28 Annotated Code of Maryland

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 (2017 Replacement Volume and 2025 Supplement)

2 BY repealing and reenacting, with amendments,
3 Article – Insurance
4 Section 15–142(f), 15–831, and 15–854
5 Annotated Code of Maryland
6 (2017 Replacement Volume and 2025 Supplement)

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

9 **Article – Health – General**

10 15–102.3.

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

13 15–103.

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

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

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

22 (III) **HAS SET AN UPPER PAYMENT LIMIT FOR THE DRUG UNDER**
23 **§ 21–2C–14 OF THIS ARTICLE.**

24 (35) (I) **IN THIS PARAGRAPH, “LIMIT, RESTRICT, OR EXCLUDE”**
25 **INCLUDES:**

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

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

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

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

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

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

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

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

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

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

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

27 **Article – Insurance**

28 15-142.

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

30 (2) “Step therapy drug” means a prescription drug or sequence of
31 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.

(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.

12 (5) "Supporting medical information" means:

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

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

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

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

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

7 (3) HAS SET AN UPPER PAYMENT LIMIT FOR THE DRUG UNDER §
8 21-2C-14 OF THE HEALTH - GENERAL ARTICLE.

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

14 (ii) easily accessible to the prescriber; and

15 (iii) posted on the entity's website.

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

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

(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:

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

6 (5) This subsection may not be construed to:

7 (i) prevent:

(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.

17 15-831.

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

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

21 (3) "Formulary" means a list of prescription drugs or devices that are
22 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.

26 (ii) "Member" includes a subscriber.

27 (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

(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.

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

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

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

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

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

23 (i) has been ineffective in treating the disease or condition of the
24 member; or

25 (ii) has caused or is likely to cause an adverse reaction or other harm
26 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.

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

6 (1) notice of the change at least 30 days before the change is implemented;
7 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.

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

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

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

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

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

4 (III) HAS SET AN UPPER PAYMENT LIMIT FOR THE DRUG UNDER
5 § 21-2C-14 OF THE HEALTH – GENERAL ARTICLE.

6 15-854.

7 (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

(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.

(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.

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

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

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

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

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

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

18 (i) if the insured changes health benefit plans that are both covered
19 by the same entity and the prescription drug is a covered benefit under the current health
20 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.

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

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

32 (ii) either in writing or electronically to all contracted health care
33 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.

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

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

9 (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.

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

16 (i) the prescription drug is:

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

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

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

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

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

6 SECTION 5. AND BE IT FURTHER ENACTED, That, except as provided in Section
7 4 of this Act, this Act shall take effect July 1, 2026.