

SENATE BILL 768

C3

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CF 7lr1203

By: **Senators Feldman, Benson, DeGrange, Klausmeier, Madaleno, Manno, Mathias, and Zucker**

Introduced and read first time: February 3, 2017

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Prescription Drugs – Formulary Changes**

3 FOR the purpose of prohibiting certain insurers, nonprofit health service plans, and health
4 maintenance organizations from making certain formulary changes during certain
5 time periods; defining a certain term; providing for the application of this Act; and
6 generally relating to formulary changes under health insurance.

7 BY repealing and reenacting, with amendments,

8 Article – Insurance

9 Section 15–831

10 Annotated Code of Maryland

11 (2011 Replacement Volume and 2016 Supplement)

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

14 **Article – Insurance**

15 15–831.

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

17 (2) “Authorized prescriber” has the meaning stated in § 12–101 of the
18 Health Occupations Article.

19 (3) “Formulary” means a list of prescription drugs or devices that are
20 covered by an entity subject to this section.

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



(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.

(5) (I) “UTILIZATION MANAGEMENT RESTRICTION” MEANS A RESTRICTION ON COVERAGE FOR A PRESCRIPTION DRUG ON A FORMULARY.

(II) “UTILIZATION MANAGEMENT RESTRICTION” INCLUDES:

1. A LIMIT ON THE QUANTITY OF A PRESCRIPTION DRUG COVERED;

2. A PRIOR AUTHORIZATION REQUIREMENT; AND

3. A STEP THERAPY PROTOCOL.

(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 benefit 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 receive a prescription drug or device that is not in the entity’s formulary in accordance with this section.

(d) The procedure shall provide for coverage for a prescription drug or device that is not in the formulary if, in the judgment of the authorized prescriber:

(1) there is no equivalent prescription drug or device in the entity’s formulary; or

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

(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.

(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) DURING A PLAN YEAR AND THE OPEN ENROLLMENT PERIOD THAT PRECEDES THE PLAN YEAR, AN ENTITY SUBJECT TO THIS SECTION MAY NOT:

(1) REMOVE A PRESCRIPTION DRUG FROM A FORMULARY;

(2) IF THE FORMULARY INCLUDES TWO OR MORE BENEFIT TIERS THAT ESTABLISH DIFFERENT DEDUCTIBLE, COPAYMENT, OR COINSURANCE REQUIREMENTS FOR PRESCRIPTION DRUGS IN EACH BENEFIT TIER, MOVE A PRESCRIPTION DRUG TO A BENEFIT TIER THAT REQUIRES AN ENROLLEE TO PAY A HIGHER DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT FOR THE PRESCRIPTION DRUG; OR

(3) EXCEPT AT THE TIME OF ENROLLMENT OR ISSUANCE OF COVERAGE, ADD A UTILIZATION MANAGEMENT RESTRICTION TO A PRESCRIPTION DRUG IN THE FORMULARY.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2017.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2017.