Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 751 (Delegate Hill)
Health and Government Operations

Health Insurance - Prior Authorization - Requirements

This bill (1) establishes requirements for an existing prior authorization when an insured transfers from one entity to another; (2) requires specified entities to provide notice of a new "utilization management restriction"; (3) prohibits prior authorization for coverage of a prescription drug or device in an "urgent care situation"; (4) establishes requirements for prior authorization for a prescription for a chronic or long-term care condition; (5) requires specified entities to maintain a database of information relating to prior authorization requests; and (6) requires an entity that denies a prior authorization to provide a specific explanation and a specified list of alternative prescription drugs. **The bill takes effect January 1, 2020, 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 (MIA) from the $125 rate and form filing fee in FY 2020 only. Review of filings can likely be handled with existing resources.

Local Effect: The bill does not directly affect local governmental operations or finances.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: The bill's provisions apply to an insurer, nonprofit health service plan, or health maintenance organization that provides coverage for prescription drugs, devices, and health care services, including coverage provided through a pharmacy benefits

manager (PBM) or a private review agent. The bill's provisions do not apply to Medicaid managed care organizations.

Prior Authorizations for Insured Individuals Transferring from One Entity to Another

When an insured transitions from one entity to another, the receiving entity must accept a prior authorization from the relinquishing entity for any covered prescription drugs, devices, or health care services for the lesser of the course of treatment or 90 days. After this period, the receiving entity may perform its own utilization review as specified.

At the request of an insured (or designee), the relinquishing entity must provide documentation of the prior authorization to the insured's receiving entity within 10 days after the receipt of the request.

Notification of New Utilization Management Restrictions

"Utilization management restriction" means a restriction on coverage for a prescription drug on a formulary, including the imposition or alteration of a quantity limit, the addition of a prior authorization requirement, and the imposition of a step-therapy protocol restriction.

If an entity revises or implements a new utilization management restriction, the entity must provide written notice to any insured who is currently authorized for coverage of a procedure, treatment, medication, or services affected by the new restriction not less than 60 days before the new restriction is implemented.

Prior Authorization for Prescriptions in Urgent Care Situations

"Urgent care situation" means a situation in which the application of the timeframe for making routine care determinations to the prescription of a drug or device for a condition would (1) jeopardize the life, health, or safety of the insured or others due to the insured's psychological state or (2) in the clinical judgment of the provider, subject the insured to adverse health consequences without the medication that is the subject of the request.

An entity may not require prior authorization for coverage of a prescription drug or device that is determined by the provider to be prescribed under an urgent care situation. After a prescription is dispensed, an entity may require the provider to submit evidence demonstrating that a prescription drug or device was prescribed under an urgent care situation.

Prior Authorization for Prescriptions for Chronic or Long-term Care Conditions

If an entity requires a prior authorization for a prescription drug or device, the prior authorization request must allow a provider to indicate whether the prescription is for a chronic or long-term care condition. If a provider indicates that the prescription is for a chronic or long-term care condition, an entity may not request a reauthorization for a repeat prescription. A repeat prescription issued by a provider for a drug or device that a provider has indicated is for a chronic or long-term care condition creates a presumption that the prescription continues to be medically necessary to treat the chronic or long-term care condition.

Database of Prior Authorization Information

If an entity requires prior authorization, the entity must maintain a database that will prepopulate prior authorization requests with an insured's available insurance and demographic information.

Explanation of Denial of Coverage and Alternative Prescription Drugs

If an entity denies coverage for a prescription drug or device, the entity must provide a detailed written explanation, including whether the denial was based on a utilization management restriction. If the denial was based on the need for prior authorization, the entity must include in the written explanation a list of the entity's covered alternative prescription drugs or devices in the same class or family that do not require prior authorization.

Current Law: A PBM is a business that administers and manages prescription drug benefit plans for purchasers. A PBM must register with MIA prior to providing pharmacy benefits management services. The Insurance Commissioner is authorized to examine the affairs, transactions, accounts, and records of a registered PBM at the PBM's expense. A PBM is prohibited from shipping, mailing, or delivering prescription drugs or devices to a person in the State through a nonresident pharmacy unless the nonresident pharmacy holds a nonresident pharmacy permit from the State Board of Pharmacy.

Small Business Effect: Small business health care providers likely experience operational efficiencies (and potentially a reduction in expenditures) in prescribing prescription drugs and obtaining prior authorization under the bill.

Additional Information

Prior Introductions: HB 1546, a similar bill, received a hearing in the House Health and Government Operations Committee but was withdrawn.

Cross File: None.

Information Source(s): Department of Budget and Management; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

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