HOUSE BILL 1233

C3 4lr1976
CF SB 622

By: **Delegates Bromwell, Cullison, Frank, Hubbard, Kach, Kipke, Morhaim, Nathan–Pulliam, Oaks, Reznik, Szeliga, Tarrant, and V. Turner**
Introduced and read first time: February 7, 2014
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Step Therapy or Fail–First Protocol

FOR the purpose of requiring the Maryland Health Care Commission to work with certain payors and providers to attain benchmarks for overriding a payor's step therapy or fail–first protocol; requiring the benchmarks to include, on or before a certain date, establishment, by each payor that requires a step therapy or fail–first protocol, of a process for a provider to override the step therapy or fail–first protocol of the payor; limiting the duration of a step therapy or fail–first protocol imposed by a certain insurer, nonprofit health service plan, or health maintenance organization; prohibiting the insurer, nonprofit health service plan, or health maintenance organization from imposing a step therapy or fail–first protocol on an insured or enrollee under certain circumstances; prohibiting certain provisions of this Act from being construed to require certain coverage; repealing certain obsolete provisions of law; defining certain terms; making certain provisions of this Act applicable to health maintenance organizations; and generally relating to step therapy or fail–first protocols in health insurance policies and contracts.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–108.2
Annotated Code of Maryland
(2009 Replacement Volume and 2013 Supplement)

BY adding to
Article – Health – General
Section 19–706(oooo)
Annotated Code of Maryland
(2009 Replacement Volume and 2013 Supplement)

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

BY adding to
Article – Insurance
Section 15–141
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

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

Article – Health – General

19–108.2.

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

(2) "Health care service" has the meaning stated in § 15–10A–01 of the Insurance Article.

(3) "Payor" means:

(i) An insurer or nonprofit health service plan that provides 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;

(ii) A health maintenance organization that provides hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; or

(iii) A pharmacy benefits manager that is registered with the Maryland Insurance Commissioner.

(4) "Provider" has the meaning stated in § 19–7A–01 of this title.

(5) "STEP THERAPY OR FAIL–FIRST PROTOCOL" HAS THE MEANING STATED IN § 15–141 OF THE INSURANCE ARTICLE.

(b) In addition to the duties stated elsewhere in this subtitle, the Commission shall work with payors and providers to attain benchmarks for**:**

(1) [standardizing**]** **STANDARDIZING** and automating the process required by payors for preauthorizing health care services**; AND**

(2) OVERRIDING A PAYOR'S STEP THERAPY OR FAIL–FIRST PROTOCOL.

(c) The benchmarks described in subsection (b) of this section shall include:

(1) On or before October 1, 2012 ("Phase 1"), establishment of online access for providers to each payor's:

(i) List of health care services that require preauthorization; and

(ii) Key criteria for making a determination on a preauthorization request;

(2) On or before March 1, 2013 ("Phase 2"), establishment by each payor of an online process for:

(i) Accepting electronically a preauthorization request from a provider; and

(ii) Assigning to a preauthorization request a unique electronic identification number that a provider may use to track the request during the preauthorization process, whether or not the request is tracked electronically, through a call center, or by fax;

(3) On or before July 1, 2013 ("Phase 3"), establishment by each payor of an online preauthorization system to approve:

(i) In real time, electronic preauthorization requests for pharmaceutical services:

1. For which no additional information is needed by the payor to process the preauthorization request; and

2. That meet the payor's criteria for approval;

(ii) Within 1 business day after receiving all pertinent information on requests not approved in real time, electronic preauthorization requests for pharmaceutical services that:

1. Are not urgent; and

2. Do not meet the standards for real–time approval under item (i) of this item; and

(iii) Within 2 business days after receiving all pertinent information, electronic preauthorization requests for health care services, except pharmaceutical services, that are not urgent; **[**and**]**

(4) ON OR BEFORE JANUARY 1, 2015, ESTABLISHMENT, BY EACH PAYOR THAT REQUIRES A STEP THERAPY OR FAIL–FIRST PROTOCOL, OF A PROCESS FOR A PROVIDER TO OVERRIDE THE STEP THERAPY OR FAIL–FIRST PROTOCOL OF THE PAYOR; AND

[(4)**] (5)** On or before July 1, 2015, utilization by providers of:

(i) The online preauthorization system established by payors; or

(ii) If a national transaction standard has been established and adopted by the health care industry, as determined by the Commission, the provider's practice management, electronic health record, or e–prescribing system.

(d) The benchmarks described in subsections (b) and (c) of this section do not apply to preauthorizations of health care services requested by providers employed by a group model health maintenance organization as defined in § 19–713.6 of this title.

(e) The online preauthorization system described in subsection (c)(3) of this section shall:

(1) Provide real–time notice to providers about preauthorization requests approved in real time; and

(2) Provide notice to providers, within the time frames specified in subsection (c)(3)(ii) and (iii) of this section and in a manner that is able to be tracked by providers, about preauthorization requests not approved in real time.

(f) (1) The Commission shall establish by regulation a process through which a payor or provider may be waived from attaining the benchmarks described in subsections (b) and (c) of this section for extenuating circumstances.

(2) For a provider, the extenuating circumstances may include:

(i) The lack of broadband Internet access;

(ii) Low patient volume; or

(iii) Not making medical referrals or prescribing pharmaceuticals.

(3) For a payor, the extenuating circumstances may include:

(i) Low premium volume; or

(ii) For a group model health maintenance organization, as defined in § 19–713.6 of this title, preauthorizations of health care services requested by providers not employed by the group model health maintenance organization.

(g) (1) On or before October 1, 2012, the Commission shall reconvene the multistakeholder workgroup whose collaboration resulted in the 2011 report "Recommendations for Implementing Electronic Prior Authorizations".

(2) The workgroup shall:

(i) Review the progress to date in attaining the benchmarks described in subsections (b) and (c) of this section; and

(ii) Make recommendations to the Commission for adjustments to the benchmark dates.

(h) **[**(1) Payors shall report to the Commission:

(i) On or before March 1, 2013, on:

1. The status of their attainment of the Phase 1 and Phase 2 benchmarks; and

2. An outline of their plans for attaining the Phase 3 benchmarks; and

(ii) On or before December 1, 2013, on their attainment of the Phase 3 benchmarks.

(2) The Commission shall specify the criteria payors must use in reporting on their attainment and plans.

(i) (1) On or before March 31, 2013, the Commission shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly, on:

(i) The progress in attaining the benchmarks for standardizing and automating the process required by payors for preauthorizing health care services; and

(ii) Taking into account the recommendations of the multistakeholder workgroup under subsection (g) of this section, any adjustment needed to the Phase 2 or Phase 3 benchmark dates.

(2)**]** On or before December 31, 2013, and on or before December 31 in each succeeding year through 2016, the Commission shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly

on the attainment of the benchmarks for standardizing and automating the process required by payors for preauthorizing health care services.

[(j)**] (I)** If necessary to attain the benchmarks, the Commission may adopt regulations to:

(1) Adjust the Phase 2 or Phase 3 benchmark dates;

(2) Require payors and providers to comply with the benchmarks; and

(3) Establish penalties for noncompliance.

19–706.

(OOOO) THE PROVISIONS OF § 15–141 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article – Insurance

15–141.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "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.

(3) "STEP THERAPY DRUG" MEANS A PRESCRIPTION DRUG OR SEQUENCE OF PRESCRIPTION DRUGS REQUIRED TO BE USED UNDER A STEP THERAPY OR FAIL–FIRST PROTOCOL.

(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.

(C) IF AN ENTITY SUBJECT TO THIS SECTION IMPOSES A STEP THERAPY OR FAIL–FIRST PROTOCOL ON AN INSURED OR ENROLLEE, THE DURATION OF THE STEP THERAPY OR FAIL–FIRST PROTOCOL MAY NOT EXCEED:

(1) ANY PERIOD AGREED TO BY THE INSURED'S OR ENROLLEE'S PRESCRIBER AND THE ENTITY TO DETERMINE THE CLINICAL EFFECTIVENESS OF THE STEP THERAPY DRUG; OR

(2) 30 DAYS.

(D) AN ENTITY SUBJECT TO THIS SECTION MAY NOT IMPOSE A STEP THERAPY OR FAIL–FIRST PROTOCOL ON AN INSURED OR ENROLLEE IF:

(1) THE STEP THERAPY DRUG HAS NOT BEEN APPROVED BY THE U.S. FOOD AND DRUG ADMINISTRATION FOR THE MEDICAL CONDITION BEING TREATED; OR

(2) A PRESCRIBER DOCUMENTS AND NOTIFIES THE ENTITY THAT A PRESCRIPTION DRUG COVERED BY THE ENTITY:

(I) WAS ORDERED BY THE PRESCRIBER FOR THE INSURED OR ENROLLEE WITHIN THE PAST 365 DAYS; AND

(II) BASED ON THE PROFESSIONAL JUDGMENT OF THE PRESCRIBER, WAS EFFECTIVE IN TREATING THE INSURED'S OR ENROLLEE'S DISEASE OR MEDICAL CONDITION.

(E) THIS SECTION MAY NOT BE CONSTRUED TO REQUIRE COVERAGE FOR A PRESCRIPTION DRUG THAT IS NOT:

(1) COVERED BY THE POLICY OR CONTRACT OF AN ENTITY SUBJECT TO THIS SECTION; OR

(2) OTHERWISE REQUIRED BY LAW TO BE COVERED.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2014.