Chapter 549

(House Bill 751)

AN ACT concerning

Health Insurance – Prior Authorization – Requirements

FOR the purpose of ~~requiring certain insurers, nonprofit health service plans, and health maintenance organizations to accept a prior authorization from a certain entity for any prescription drugs, devices, or health care services for a certain period of time; requiring a certain entity, under certain circumstances, to provide documentation of a prior authorization within a certain time after a request by an insured or an insured's designee; authorizing a certain entity to perform utilization review under certain circumstances; requiring a certain entity to provide certain insureds written notice of new utilization management restrictions within a certain time period; prohibiting certain insurers, nonprofit health service plans, and health maintenance organizations from requiring prior authorization for coverage of a prescription drug or device under certain circumstances; authorizing a certain entity to require a health care provider to submit evidence demonstrating that a prescription drug or device was prescribed under an urgent care situation;~~ requiring a certain entity to allow a health care provider to indicate whether a prescription drug ~~or device~~ is to be used to treat a certain condition; prohibiting an entity from requesting a reauthorization for a repeat prescription for a certain period of time under certain circumstances; ~~providing that a repeat prescription issued by a health care provider for a drug or device that a health care provider has indicated is to treat a certain condition creates a presumption that the prescription continues to be medically necessary to treat a certain condition;~~ requiring a certain entity to maintain a certain database for certain prior authorizations; requiring an entity, under certain circumstances, to provide a detailed written explanation for a denial of coverage; ~~requiring that a certain detailed written explanation include certain information under certain circumstances; defining certain terms;~~ requiring certain entities to honor a prior authorization from a certain entity for benefits for at least a certain amount of time; authorizing a certain entity to perform a certain review during a certain period of time; requiring a certain entity to honor a prior authorization issued by the entity under certain circumstances; providing that a certain entity may not be required to honor a certain prior authorization for a change in dosage of an opioid; requiring a certain entity, under certain circumstances, to provide certain notice of a certain prior authorization requirement to certain persons; providing for a delayed effective date; providing for the application of this Act; and generally relating to prior authorization required by insurers, nonprofit health service plans, and health maintenance organizations.

BY adding to
Article – Insurance
Section ~~15–140.1 and~~ 15–854
Annotated Code of Maryland

(2017 Replacement Volume and 2018 Supplement)

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

Article – Insurance

~~**15–140.1.**~~

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

~~**(2) "PRIOR AUTHORIZATION" MEANS A UTILIZATION MANAGEMENT RESTRICTION TECHNIQUE THAT:**~~

~~**(I) REQUIRES PRIOR APPROVAL FOR A PROCEDURE, TREATMENT, MEDICATION, OR SERVICE BEFORE AN ENROLLEE IS ELIGIBLE FOR FULL PAYMENT OF THE BENEFIT; AND**~~

~~**(II) IS USED TO DETERMINE WHETHER THE PROCEDURE, TREATMENT, MEDICATION, OR SERVICE IS MEDICALLY NECESSARY.**~~

~~**(3) (I) "UTILIZATION MANAGEMENT RESTRICTION" MEANS A RESTRICTION ON COVERAGE FOR A PRESCRIPTION DRUG ON A FORMULARY.**~~

~~**(II) "UTILIZATION MANAGEMENT RESTRICTION" INCLUDES:**~~

~~**1. THE IMPOSITION OR ALTERATION OF A QUANTITY LIMIT FOR A PRESCRIPTION DRUG;**~~

~~**2. THE ADDITION OF A REQUIREMENT THAT AN ENROLLEE RECEIVE A PRIOR AUTHORIZATION REQUIREMENT FOR A PRESCRIPTION DRUG; AND**~~

~~**3. THE IMPOSITION OF A STEP THERAPY PROTOCOL RESTRICTION FOR A DRUG.**~~

~~**(B) (1) THIS SECTION APPLIES TO:**~~

~~**(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE COVERAGE FOR PRESCRIPTION DRUGS, DEVICES, AND HEALTH CARE SERVICES 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, DEVICES, AND HEALTH CARE SERVICES 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, DEVICES, AND HEALTH CARE SERVICES THROUGH A PHARMACY BENEFIT MANAGER OR THAT CONTRACTS WITH A PRIVATE REVIEW AGENT UNDER SUBTITLE 10B OF THIS ARTICLE 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) (1) WHEN AN INSURED TRANSITIONS FROM ONE ENTITY SUBJECT TO THIS SECTION TO ANOTHER ENTITY SUBJECT TO THIS SECTION, THE RECEIVING ENTITY SHALL ACCEPT A PRIOR AUTHORIZATION FROM THE RELINQUISHING ENTITY FOR ANY PRESCRIPTION DRUGS, DEVICES, OR HEALTH CARE SERVICES COVERED BY THE RECEIVING ENTITY FOR THE LESSER OF THE COURSE OF TREATMENT OR 90 DAYS.~~

~~(2) SUBJECT TO APPLICABLE FEDERAL AND STATE LAWS CONCERNING CONFIDENTIALITY OF MEDICAL RECORDS, AT THE REQUEST OF AN INSURED OR THE INSURED'S DESIGNEE, THE RELINQUISHING ENTITY SHALL PROVIDE DOCUMENTATION OF THE PRIOR AUTHORIZATION TO THE INSURED'S RECEIVING ENTITY WITHIN 10 DAYS AFTER THE RECEIPT OF THE REQUEST.~~

~~(3) AFTER THE TIME PERIOD UNDER PARAGRAPH (1) OF THIS SUBSECTION HAS LAPSED, THE RECEIVING ENTITY MAY PERFORM ITS OWN UTILIZATION REVIEW TO:~~

~~(I) REASSESS AND MAKE DETERMINATIONS REGARDING THE NEED FOR CONTINUED TREATMENT; AND~~

~~(II) AUTHORIZE ANY CONTINUED PROCEDURE, TREATMENT, MEDICATION, OR SERVICES DETERMINED TO BE MEDICALLY NECESSARY BY THE RECEIVING ENTITY.~~

~~(D) IF AN ENTITY SUBJECT TO THIS SECTION REVISES OR IMPLEMENTS A NEW UTILIZATION MANAGEMENT RESTRICTION, THE ENTITY SHALL PROVIDE TO ANY INSURED WHO IS CURRENTLY AUTHORIZED FOR COVERAGE OF A PROCEDURE, TREATMENT, MEDICATION, OR SERVICES AFFECTED BY THE NEW UTILIZATION MANAGEMENT RESTRICTION WRITTEN NOTICE OF THE NEW UTILIZATION~~

~~MANAGEMENT RESTRICTION AND REQUIREMENTS NOT LESS THAN 60 DAYS BEFORE THE NEW UTILIZATION MANAGEMENT RESTRICTION IS IMPLEMENTED.~~

15–854.

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

~~(2) "PRIOR AUTHORIZATION" MEANS A UTILIZATION MANAGEMENT TECHNIQUE THAT:~~

~~(I) REQUIRES PRIOR APPROVAL FOR A PROCEDURE, TREATMENT, MEDICATION, OR SERVICE BEFORE AN ENROLLEE IS ELIGIBLE FOR FULL PAYMENT OF THE BENEFIT; AND~~

~~(II) IS USED TO DETERMINE WHETHER THE PROCEDURE, TREATMENT, MEDICATION, OR SERVICE IS MEDICALLY NECESSARY.~~

~~(3) "URGENT CARE SITUATION" MEANS A SITUATION IN WHICH THE APPLICATION OF THE TIME FRAME FOR MAKING ROUTINE CARE DETERMINATIONS TO THE PRESCRIPTION OF A DRUG OR DEVICE FOR A CONDITION WOULD:~~

~~(I) JEOPARDIZE THE LIFE, HEALTH, OR SAFETY OF THE INSURED OR OTHERS DUE TO THE INSURED'S PSYCHOLOGICAL STATE; OR~~

~~(II) IN THE CLINICAL JUDGMENT OF THE HEALTH CARE PROVIDER, SUBJECT THE INSURED TO ADVERSE HEALTH CONSEQUENCES WITHOUT THE MEDICATION THAT IS THE SUBJECT OF THE REQUEST.~~

~~(4) (I) "UTILIZATION MANAGEMENT RESTRICTION" MEANS A RESTRICTION ON COVERAGE FOR A PRESCRIPTION DRUG ON A FORMULARY.~~

~~(II) "UTILIZATION MANAGEMENT RESTRICTION" INCLUDES:~~

~~1. THE IMPOSITION OR ALTERATION OF A QUANTITY LIMIT FOR A PRESCRIPTION DRUG;~~

~~2. THE ADDITION OF A REQUIREMENT THAT AN ENROLLEE RECEIVE A PRIOR AUTHORIZATION REQUIREMENT FOR A PRESCRIPTION DRUG; AND~~

~~3. THE IMPOSITION OF A STEP THERAPY PROTOCOL RESTRICTION FOR A DRUG.~~

~~(B)~~ (A) (1) THIS SECTION APPLIES TO:

(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE COVERAGE FOR PRESCRIPTION DRUGS ~~OR DEVICES~~ 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 ~~OR DEVICES~~ 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 ~~OR DEVICES~~ THROUGH A PHARMACY ~~BENEFIT~~ BENEFITS MANAGER OR THAT CONTRACTS WITH A PRIVATE REVIEW AGENT UNDER SUBTITLE 10B OF THIS ARTICLE 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) (1) AN ENTITY SUBJECT TO THIS SECTION MAY NOT REQUIRE PRIOR AUTHORIZATION FOR COVERAGE OF A PRESCRIPTION DRUG OR DEVICE THAT IS DETERMINED BY THE HEALTH CARE PROVIDER TO BE PRESCRIBED UNDER AN URGENT CARE SITUATION.~~

~~(2) AFTER A PRESCRIPTION DRUG IS DISPENSED, AN ENTITY MAY REQUIRE THE HEALTH CARE PROVIDER TO SUBMIT EVIDENCE DEMONSTRATING THAT A PRESCRIPTION DRUG OR DEVICE WAS PRESCRIBED UNDER AN URGENT CARE SITUATION.~~

~~(D)~~ (B) (1) (I) IF AN ENTITY SUBJECT TO THIS SECTION REQUIRES A PRIOR AUTHORIZATION FOR A PRESCRIPTION DRUG ~~OR DEVICE~~, THE PRIOR AUTHORIZATION REQUEST SHALL ALLOW A HEALTH CARE PROVIDER TO INDICATE WHETHER A PRESCRIPTION DRUG ~~OR DEVICE~~ IS TO BE USED TO TREAT A CHRONIC ~~OR LONG–TERM CARE~~ CONDITION.

(II) IF A HEALTH CARE PROVIDER INDICATES THAT THE PRESCRIPTION DRUG ~~OR DEVICE~~ IS TO TREAT A CHRONIC ~~OR LONG–TERM CARE~~ CONDITION, AN ENTITY SUBJECT TO THIS SECTION MAY NOT REQUEST A REAUTHORIZATION FOR A REPEAT PRESCRIPTION FOR THE PRESCRIPTION DRUG ~~OR DEVICE~~ FOR 1 YEAR OR FOR THE STANDARD COURSE OF TREATMENT FOR THE CHRONIC CONDITION BEING TREATED, WHICHEVER IS LESS.

~~(III) A REPEAT PRESCRIPTION ISSUED BY A HEALTH CARE PROVIDER FOR A DRUG OR DEVICE THAT A HEALTH CARE PROVIDER HAS INDICATED IS TO TREAT 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.~~

(2) ~~IF AN ENTITY SUBJECT TO THIS SECTION REQUIRES PRIOR AUTHORIZATION~~ 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.

~~(E)~~ ~~(1)~~ (C) IF AN ENTITY SUBJECT TO THIS SECTION DENIES COVERAGE FOR A PRESCRIPTION DRUG ~~OR DEVICE~~, THE ENTITY SHALL PROVIDE A DETAILED WRITTEN EXPLANATION FOR THE DENIAL OF COVERAGE, INCLUDING WHETHER THE DENIAL WAS BASED ON A ~~UTILIZATION MANAGEMENT RESTRICTION~~ REQUIREMENT FOR PRIOR AUTHORIZATION.

~~(2) IF THE DENIAL WAS BASED ON THE NEED FOR A PRIOR AUTHORIZATION, THE ENTITY SHALL INCLUDE IN THE WRITTEN EXPLANATION REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION A LIST OF THE ENTITY'S COVERED ALTERNATIVE PRESCRIPTION DRUGS OR DEVICES IN THE SAME CLASS OR FAMILY THAT DO NOT REQUIRE A PRIOR AUTHORIZATION.~~

(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 INITIAL 30 DAYS OF AN INSURED'S PRESCRIPTION DRUG BENEFIT COVERAGE UNDER THE HEALTH BENEFIT PLAN OF THE NEW ENTITY.

(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.

(E) (1) AN ENTITY SUBJECT TO THIS SECTION SHALL HONOR A PRIOR AUTHORIZATION ISSUED BY THE ENTITY FOR A 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) AN ENTITY MAY NOT BE REQUIRED TO HONOR A PRIOR AUTHORIZATION FOR A CHANGE IN DOSAGE FOR AN OPIOID UNDER THIS SUBSECTION.

(F) 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 30 DAYS BEFORE THE IMPLEMENTATION OF A NEW PRIOR AUTHORIZATION REQUIREMENT:

(1) IN WRITING TO ANY INSURED WHO IS PRESCRIBED THE PRESCRIPTION DRUG; AND

(2) EITHER IN WRITING OR ELECTRONICALLY TO ALL CONTRACTED HEALTH CARE PROVIDERS.

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 January 1, 2020.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2020.

Approved by the Governor, May 13, 2019.