HOUSE BILL 751

C3 9lr2139

By: **Delegate Hill**
Introduced and read first time: February 8, 2019
Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Prior Authorization – Requirements**

3 FOR the purpose of requiring certain insurers, nonprofit health service plans, and health
4 maintenance organizations to accept a prior authorization from a certain entity for
5 any prescription drugs, devices, or health care services for a certain period of time;
6 requiring a certain entity, under certain circumstances, to provide documentation of
7 a prior authorization within a certain time after a request by an insured or an
8 insured's designee; authorizing a certain entity to perform utilization review under
9 certain circumstances; requiring a certain entity to provide certain insureds written
10 notice of new utilization management restrictions within a certain time period;
11 prohibiting certain insurers, nonprofit health service plans, and health maintenance
12 organizations from requiring prior authorization for coverage of a prescription drug
13 or device under certain circumstances; authorizing a certain entity to require a
14 health care provider to submit evidence demonstrating that a prescription drug or
15 device was prescribed under an urgent care situation; requiring a certain entity to
16 allow a health care provider to indicate whether a prescription drug or device is to
17 be used to treat a certain condition; prohibiting an entity from requesting a
18 reauthorization for a repeat prescription under certain circumstances; providing that
19 a repeat prescription issued by a health care provider for a drug or device that a
20 health care provider has indicated is to treat a certain condition creates a
21 presumption that the prescription continues to be medically necessary to treat a
22 certain condition; requiring a certain entity to maintain a certain database; requiring
23 an entity, under certain circumstances, to provide a detailed written explanation for
24 a denial of coverage; requiring that a certain detailed written explanation include
25 certain information under certain circumstances; defining certain terms; providing
26 for a delayed effective date; providing for the application of this Act; and generally
27 relating to prior authorization required by insurers, nonprofit health service plans,
28 and health maintenance organizations.

29 BY adding to
30 Article – Insurance

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

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

1 OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

2 (II) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE
3 COVERAGE FOR PRESCRIPTION DRUGS, DEVICES, AND HEALTH CARE SERVICES
4 UNDER INDIVIDUAL OR GROUP CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE
5 STATE.

6 (2) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH
7 MAINTENANCE ORGANIZATION THAT PROVIDES COVERAGE FOR PRESCRIPTION
8 DRUGS, DEVICES, AND HEALTH CARE SERVICES THROUGH A PHARMACY BENEFIT
9 MANAGER OR THAT CONTRACTS WITH A PRIVATE REVIEW AGENT UNDER SUBTITLE
10 10B OF THIS ARTICLE IS SUBJECT TO THE REQUIREMENTS OF THIS SECTION.

11 (3) THIS SECTION DOES NOT APPLY TO A MANAGED CARE
12 ORGANIZATION AS DEFINED IN § 15–101 OF THE HEALTH – GENERAL ARTICLE.

13 (C) (1) WHEN AN INSURED TRANSITIONS FROM ONE ENTITY SUBJECT TO
14 THIS SECTION TO ANOTHER ENTITY SUBJECT TO THIS SECTION, THE RECEIVING
15 ENTITY SHALL ACCEPT A PRIOR AUTHORIZATION FROM THE RELINQUISHING ENTITY
16 FOR ANY PRESCRIPTION DRUGS, DEVICES, OR HEALTH CARE SERVICES COVERED BY
17 THE RECEIVING ENTITY FOR THE LESSER OF THE COURSE OF TREATMENT OR 90
18 DAYS.

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

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

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

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

32 (D) IF AN ENTITY SUBJECT TO THIS SECTION REVISES OR IMPLEMENTS A
33 NEW UTILIZATION MANAGEMENT RESTRICTION, THE ENTITY SHALL PROVIDE TO
34 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

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

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

4 **(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT**
5 **PROVIDE COVERAGE FOR PRESCRIPTION DRUGS OR DEVICES UNDER INDIVIDUAL,**
6 **GROUP, OR BLANKET HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE**
7 **ISSUED OR DELIVERED IN THE STATE; AND**

8 **(II) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE**
9 **COVERAGE FOR PRESCRIPTION DRUGS OR DEVICES UNDER INDIVIDUAL OR GROUP**
10 **CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.**

11 **(2) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH**
12 **MAINTENANCE ORGANIZATION THAT PROVIDES COVERAGE FOR PRESCRIPTION**
13 **DRUGS OR DEVICES THROUGH A PHARMACY BENEFIT MANAGER OR THAT**
14 **CONTRACTS WITH A PRIVATE REVIEW AGENT UNDER SUBTITLE 10B OF THIS**
15 **ARTICLE IS SUBJECT TO THE REQUIREMENTS OF THIS SECTION.**

16 **(3) THIS SECTION DOES NOT APPLY TO A MANAGED CARE**
17 **ORGANIZATION AS DEFINED IN § 15–101 OF THE HEALTH – GENERAL ARTICLE.**

18 **(C) (1) AN ENTITY SUBJECT TO THIS SECTION MAY NOT REQUIRE PRIOR**
19 **AUTHORIZATION FOR COVERAGE OF A PRESCRIPTION DRUG OR DEVICE THAT IS**
20 **DETERMINED BY THE HEALTH CARE PROVIDER TO BE PRESCRIBED UNDER AN**
21 **URGENT CARE SITUATION.**

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

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

31 **(II) IF A HEALTH CARE PROVIDER INDICATES THAT THE**
32 **PRESCRIPTION DRUG OR DEVICE IS TO TREAT A CHRONIC OR LONG–TERM CARE**
33 **CONDITION, AN ENTITY SUBJECT TO THIS SECTION MAY NOT REQUEST A**
34 **REAUTHORIZATION FOR A REPEAT PRESCRIPTION FOR THE PRESCRIPTION DRUG**

1 **OR DEVICE.**

2 **(III) A REPEAT PRESCRIPTION ISSUED BY A HEALTH CARE**
3 **PROVIDER FOR A DRUG OR DEVICE THAT A HEALTH CARE PROVIDER HAS INDICATED**
4 **IS TO TREAT A CHRONIC OR LONG–TERM CARE CONDITION CREATES A**
5 **PRESUMPTION THAT THE PRESCRIPTION CONTINUES TO BE MEDICALLY NECESSARY**
6 **TO TREAT THE CHRONIC OR LONG–TERM CARE CONDITION.**

7 **(2) IF AN ENTITY SUBJECT TO THIS SECTION REQUIRES PRIOR**
8 **AUTHORIZATION, THE ENTITY SHALL MAINTAIN A DATABASE THAT WILL**
9 **PREPOPULATE PRIOR AUTHORIZATION REQUESTS WITH AN INSURED'S AVAILABLE**
10 **INSURANCE AND DEMOGRAPHIC INFORMATION.**

11 **(E) (1) IF AN ENTITY SUBJECT TO THIS SECTION DENIES COVERAGE FOR**
12 **A PRESCRIPTION DRUG OR DEVICE, THE ENTITY SHALL PROVIDE A DETAILED**
13 **WRITTEN EXPLANATION FOR THE DENIAL OF COVERAGE, INCLUDING WHETHER THE**
14 **DENIAL WAS BASED ON A UTILIZATION MANAGEMENT RESTRICTION.**

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

20 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all
21 policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or
22 after January 1, 2020.

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