HB 751

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 751 (Delegate Hill)
Health and Government Operations Finance

Health Insurance - Prior Authorization - Requirements

This bill establishes requirements for prior authorization for a prescription for a chronic condition and requires specified entities to (1) maintain a database of information relating to prior authorization requests filed electronically; (2) provide a specific explanation when denying a prior authorization; (3) honor certain prior authorizations for a specified time period and under specified circumstances; and (4) provide specified notice of a new prior authorization requirement for a prescription drug. **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 through a pharmacy benefit, including coverage provided through a pharmacy benefits manager (PBM) or a private review agent. The bill's provisions do not apply to a Medicaid managed care organization.

Prior Authorization for Prescriptions for Chronic Conditions

If an entity requires a prior authorization for a prescription drug, the prior authorization request must allow a provider to indicate whether the prescription is for a chronic condition. If a provider indicates that the prescription is for a chronic condition, an entity may not request a reauthorization for a repeat prescription for one year or for the standard course of treatment for the chronic condition, whichever is less.

Database of Prior Authorization Information

For a prior authorization that is filed electronically, 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

If an entity denies coverage for a prescription drug, the entity must provide a detailed written explanation, including whether the denial was based on a requirement for prior authorization.

Honoring Prior Authorization Granted by Another Entity

On receipt of information documenting a prior authorization from the insured or from the insured's health care provider, an entity must honor a prior authorization granted to an insured from a previous entity for at least the first 30 days of the insured's prescription drug benefit coverage under the health benefit plan of the new entity. During the 30-day period, an entity may perform its own review to grant a prior authorization for the prescription drug.

An entity must honor a prior authorization issued by the entity for a prescription drug (1) 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 (2) when the dosage for the approved prescription drug changes and the change is consistent with federal Food and Drug Administration labeled dosages. An entity may not be required to honor a prior authorization for a change in dosage for an opioid.

Notice of New Prior Authorization Requirements

If an entity implements a new prior authorization requirement for a prescription drug, the entity must provide notice of the new requirement at least 30 days before implementation. Notice must be provided (1) in writing to any insured who is prescribed the prescription drug and (2) in writing or electronically to all contracted health care providers.

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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