SENATE BILL 688

J5, J4 2lr2851

By: **Senator Ready**
Introduced and read first time: February 4, 2022
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Utilization Review for Coverage of Prescription Drugs and Devices – Expedited Appeals

FOR the purpose of establishing certain requirements on utilization review of prescription drug and device coverage by health insurers, nonprofit health service plans, and health maintenance organizations; providing that a denial of coverage for a prescription drug or device made during the course of utilization review is eligible for an expedited appeal under certain circumstances; prohibiting utilization review of certain prescription drugs by health insurers, nonprofit health service plans, and health maintenance organizations; and generally relating to health insurance carriers and utilization review of prescription drugs and devices.

BY adding to
Article – Insurance
Section 15–1012
Annotated Code of Maryland
(2017 Replacement Volume and 2021 Supplement)

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

Article – Insurance

15–1012.

(A) (1) THIS SECTION APPLIES TO:

(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE COVERAGE FOR PRESCRIPTION DRUGS AND DEVICES UNDER INDIVIDUAL,

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

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 AND DEVICES UNDER INDIVIDUAL OR GROUP CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.

(2) AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION THAT PROVIDES COVERAGE FOR PRESCRIPTION DRUGS AND DEVICES THROUGH A PHARMACY BENEFITS MANAGER 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.

(B) (1) A DENIAL OF COVERAGE FOR A PRESCRIPTION DRUG OR DEVICE MADE DURING THE COURSE OF UTILIZATION REVIEW BY AN ENTITY SUBJECT TO THIS SECTION SHALL BE MADE BY A PHYSICIAN:

(I) WHO IS IN THE SAME SPECIALTY AS THE PRESCRIBER OF THE PRESCRIPTION DRUG OR DEVICE SUBJECT TO UTILIZATION REVIEW; OR

(II) WHOSE SPECIALTY FOCUSES ON THE DIAGNOSIS AND TREATMENT OF THE CONDITION FOR WHICH THE PRESCRIPTION DRUG OR DEVICE WAS PROVIDED TO TREAT.

(2) AN ENTITY SUBJECT TO THIS SECTION IS NOT REQUIRED TO INVOLVE A PHYSICIAN IN THE UTILIZATION REVIEW OF A PRESCRIPTION DRUG OR DEVICE IF THE REVIEW DOES NOT RESULT IN THE DENIAL OF COVERAGE OF A PRESCRIPTION DRUG OR DEVICE.

(C) (1) A DENIAL OF COVERAGE FOR A PRESCRIPTION DRUG OR DEVICE MADE DURING THE COURSE OF UTILIZATION REVIEW SHALL BE ELIGIBLE FOR AN EXPEDITED APPEAL IF THE PRESCRIBER OF THE PRESCRIPTION DRUG OR DEVICE SUBJECT TO UTILIZATION REVIEW BELIEVES THAT, IN THE PROFESSIONAL JUDGMENT OF THE PRESCRIBER, THE INSURED OR ENROLLEE WILL SUFFER SERIOUS HARM WITHOUT ACCESS TO THE PRESCRIPTION DRUG SUBJECT TO UTILIZATION REVIEW.

(2) ON INITIATION OF THE EXPEDITED APPEAL BY THE PRESCRIBER OF THE PRESCRIPTION DRUG OR DEVICE SUBJECT TO UTILIZATION REVIEW, AN ENTITY SUBJECT TO THIS SECTION SHALL RENDER A DECISION ON THE EXPEDITED APPEAL WITHIN 48 HOURS.

(3) IF AN ENTITY SUBJECT TO THIS SECTION DOES NOT RENDER A DECISION ON THE EXPEDITED APPEAL INITIATED BY THE PRESCRIBER OF THE PRESCRIPTION DRUG OR DEVICE SUBJECT TO UTILIZATION REVIEW WITHIN 48 HOURS AFTER INITIATION, THE INITIAL DENIAL OF COVERAGE SHALL BE AUTOMATICALLY OVERTURNED AND THE INSURED OR ENROLLEE SHALL BE GRANTED IMMEDIATE APPROVAL FOR COVERAGE OF THE PRESCRIPTION DRUG OR DEVICE.

(4) THE DECISION RENDERED DURING THE EXPEDITED APPEAL BY THE ENTITY SUBJECT TO THIS SECTION:

(I) SHALL BE MADE BY A PHYSICIAN:

1. WHO IS IN THE SAME SPECIALTY AS THE PRESCRIBER OF THE PRESCRIPTION DRUG OR DEVICE SUBJECT TO UTILIZATION REVIEW; OR

2. WHOSE SPECIALTY FOCUSES ON THE DIAGNOSIS AND TREATMENT OF THE CONDITION FOR WHICH THE PRESCRIPTION DRUG OR DEVICE WAS PROVIDED TO TREAT; AND

(II) MAY NOT BE MADE BY THE SAME PHYSICIAN WHO RENDERED THE INITIAL DENIAL OF COVERAGE FOR THE PRESCRIPTION DRUG OR DEVICE SUBJECT TO UTILIZATION REVIEW.

(5) THE EXPEDITED APPEAL PROCESS ESTABLISHED UNDER THIS SUBSECTION SHALL BE INDEPENDENT AND DISTINCT FROM THE APPEALS PROCESS ESTABLISHED UNDER § 15–10D–02 OF THIS TITLE OR THE INTERNAL GRIEVANCE PROCESS ESTABLISHED UNDER SUBTITLE 10A OF THIS TITLE.

(D) AN ENTITY SUBJECT TO THIS SECTION MAY NOT PERFORM UTILIZATION REVIEW ON PRESCRIPTION DRUGS UNDER THE FOLLOWING CIRCUMSTANCES:

(1) FOR GENERIC PRESCRIPTION DRUGS THAT ARE NOT LISTED WITHIN ANY OF THE SCHEDULES OF CONTROLLED SUBSTANCES FOUND UNDER 21 C.F.R. 1308.11 THROUGH 21 C.F.R. 1308.15 OR THE SCHEDULES OF CONTROLLED DANGEROUS SUBSTANCES FOUND UNDER §§ 5–402 THROUGH 5–406 OF THE CRIMINAL LAW ARTICLE;

(2) FOR ANY PRESCRIPTION DRUG, GENERIC OR BRAND NAME, THAT IS NOT LISTED WITHIN ANY OF THE SCHEDULES OF CONTROLLED SUBSTANCES FOUND UNDER §§ 5–402 THROUGH 5–406 OF THE CRIMINAL LAW ARTICLE, AFTER

AN INSURED OR ENROLLEE HAS BEEN PRESCRIBED THE DRUG WITHOUT INTERRUPTION FOR 6 MONTHS;

(3) FOR ANY PRESCRIPTION DRUG OR DRUGS, GENERIC OR BRAND NAME, ON THE GROUND OF THERAPEUTIC DUPLICATION IF THE INSURED OR ENROLLEE HAS ALREADY BEEN SUBJECT TO UTILIZATION REVIEW ON THE GROUND OF THERAPEUTIC DUPLICATION FOR THE SAME DOSAGE OF THE PRESCRIPTION DRUG OR DRUGS AND COVERAGE OF THE PRESCRIPTION DRUG OR DRUGS WAS APPROVED; AND

(4) FOR ANY PRESCRIPTION DRUG, GENERIC OR BRAND NAME, SOLELY BECAUSE THE DOSAGE OF THE MEDICATION FOR THE INSURED OR ENROLLEE HAS BEEN ADJUSTED BY THE PRESCRIBER OF THE PRESCRIPTION DRUG.

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, 2023.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2023.