L.D. 1496

Date: (Filing No. H-)

HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

132ND LEGISLATURE

FIRST SPECIAL SESSION

COMMITTEE AMENDMENT " " to H.P. 980, L.D. 1496, "An Act to Ensure Ongoing Access to Medications and Care for Chronic Conditions and Conditions Requiring Long-term Care by Changing Requirements for Prior Authorizations"

Amend the bill by striking out the title and substituting the following:

'An Act to Ensure Ongoing Access to Medications and Care for Chronic Conditions by Changing Requirements for Prior Authorizations'

Amend the bill by striking out everything after the enacting clause and inserting the following:

'**Sec. 1. 24-A MRSA §4304-B** is enacted to read:

§4304-B. Prior authorization for treatment of chronic conditions

1. Length of prior authorization for treatment of chronic conditions. If a carrier requires a prior authorization for health care services for the treatment of a chronic condition, the approved prior authorization remains valid for the duration of the treatment or for one year, whichever is longer. If health care services for the treatment of a chronic condition are necessary for more than one year, a carrier may not require the renewal of the prior authorization more frequently than once every 3 years. The prior authorization approval is valid from the date the enrollee receives the notice of the approval. If an enrollee has received prior authorization for health care services for the treatment of a chronic condition, the carrier shall honor the prior authorization until the prior authorization expires as long as the enrollee continues to be covered under the same health plan.

2. Length of prior authorization for diagnostic procedures or tests related to treatment of chronic conditions. A prior authorization for a diagnostic procedure or test related to the treatment of a chronic condition remains valid for subsequent, necessary recurring orders of the diagnostic procedure or test for the duration of the diagnosis of the chronic condition or for one year, whichever is longer. A carrier may not require the renewal of a prior authorization more frequently than once every 3 years for a diagnostic procedure or test that continues for more than one year, and the prior authorization remains valid from the date the enrollee receives notice of the approval.

3. Coverage restriction prohibition; notice. A carrier may not restrict coverage for a health care service, diagnostic procedure or test used in the treatment of a chronic condition under this section, including coverage for a prescription, that received prior authorization approval under a previous carrier within 90 days of enrollment in the carrier's health plan by an enrollee if that enrollee's health care provider determines that the enrollee should continue receiving that health care service, diagnostic procedure or test as determined by a health care provider. The carrier shall provide the enrollee with at least 90 days' notice prior to restricting coverage pursuant to this subsection.

4. Chronic condition. For the purposes of this section, "chronic condition" means a medical condition diagnosed by a health care provider that is expected to last 6 months or more and that:

A. Requires ongoing medical attention by a health care provider to effectively manage the condition or to prevent an adverse health event; or

B. Limits one or more activities of daily living, as defined in Title 22, section 1717, subsection 1, paragraph A.

Sec. 2. 24-A MRSA §4311, sub-§1-A, ¶A, as amended by PL 2019, c. 273, §3, is further amended to read:

A. The carrier must determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has issued the valid prescription for the enrollee of its coverage decision within 72 hours or 2 business days, whichever is less, following receipt of the request. A carrier that grants coverage under this paragraph must provide coverage of the drug for the duration of the prescription, including refills. A prior authorization for a prescription is valid for the duration of the prescription, including refills, or for one year, whichever is longer. A carrier may not require the renewal of a prior authorization more frequently than once every 3 years for a prescription that continues for more than one year. The prior authorization approval is valid from the date the enrollee receives notice of the approval and remains valid for a prescription drug prescribed by a provider regardless of a change in dosage. A carrier may rescind the prior authorization approval for prescription drug doses that exceed limitations set by federal or state law, regulation or rule.

Sec. 3. Appropriations and allocations. The following appropriations and allocations are made.

ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF

Departments and Agencies - Statewide 0016

Initiative: Provides funding to expand coverage for enrollees with chronic conditions. The expanded requirements apply to health plans issued or renewed on or after January 1, 2026.

GENERAL FUND	**2025-26**	**2026-27**
All Other	$0	$1,779,648
GENERAL FUND TOTAL	$0	$1,779,648

HIGHWAY FUND	**2025-26**	**2026-27**
All Other	$0	$619,008

HIGHWAY FUND TOTAL	$0	$619,008

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Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment, which is the majority report of the committee, replaces the bill and changes the title. It narrows the scope of the prior authorization process required by health insurance carriers to chronic conditions and removes language related to conditions requiring long-term care used in the bill. The amendment defines "chronic condition" and clarifies that the limits placed on carriers related to prior authorizations extend to health care services for the treatment of a chronic condition and to diagnostic procedures or tests related to the treatment of a chronic condition. It prohibits a carrier from requiring the renewal of a prior authorization more frequently than once every 3 years for treatment that is necessary for more than one year, instead of 5 years as proposed in the bill. Finally, the amendment removes the provision in the bill that prohibits a health care plan from restricting coverage for a health care service or a prescription that was approved under a previous health care plan within 90 days of enrollment in the new health care plan because it is duplicative of requirements in existing law. The amendment also adds an appropriations and allocations section.

FISCAL NOTE REQUIRED

(See attached)