PLEASE NOTE: Legislative Information ***cannot*** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

An Act Regarding Prior Authorizations for Prescription Drugs

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §4301-A, sub-§10-A, as enacted by PL 2001, c. 288, §3, is amended to read:

10-A. Medically necessary health care. "Medically necessary health care" means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

A. ~~Consistent~~<u>Evidence-based and consistent</u> with generally accepted standards of medical practice;

B. Clinically appropriate in terms of type, frequency, extent, site and duration;

C. Demonstrated through scientific evidence <u>in peer-reviewed medical literature</u> to be effective in improving health outcomes;

D. Representative of "best practices" in the medical profession; ~~and~~

E. Not primarily for the convenience of the enrollee or physician or other health care practitioner~~.~~<u>; and</u>

<u>F. With respect to pharmacy services, not primarily based on the cost of a medication.</u>

Sec. 2. 24-A MRSA §4301-A, sub-§13, as enacted by PL 1999, c. 742, §3, is amended to read:

13. Participating provider. "Participating provider" means a licensed or certified provider of health care services, including mental health services <u>and pharmacy services</u>, or health care supplies that has entered into an agreement with a carrier to provide those services or supplies to an individual enrolled in a managed care plan.

Sec. 3. 24-A MRSA §4301-A, sub-§14-A is enacted to read:

<u>**14-A. Pharmacy benefits manager.** "Pharmacy benefits manager" has the same meaning as in section 4347, subsection 17.</u>

Sec. 4. 24-A MRSA §4301-A, sub-§15-A is enacted to read:

<u>**15-A. Prior authorization.** "Prior authorization" means a utilization review process used by a carrier:</u>

<u>A. As an educational tool to ensure that enrollees and providers have the most appropriate evidence-based health care options for diagnosis and treatment of the enrollees' medical conditions; and</u>

B. To determine if the carrier will cover a prescribed procedure, medication, service, treatment or laboratory or diagnostic test, prescribed durable medical equipment or a prescribed prosthetic device based on medical necessity, the availability of generic alternatives or the potential for drug interactions.

Sec. 5. 24-A MRSA §4304, sub-§2, as amended by PL 2019, c. 273, §1, is further amended to read:

2. Prior authorization of nonemergency services. Except for a request in exigent circumstances as described in section 4311, subsection 1-A, paragraph B, a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection.

A. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination.

B. If the carrier responds to a request by a provider for prior authorization with a request for additional information, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, after receiving the requested information.

C. If the carrier responds that outside consultation is necessary before making a decision, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, from the time of the carrier's initial response.

D. The prior authorization standards used by a carrier must be clear and readily available to enrollees, participating providers, pharmacists and other providers. With regard to prior authorization for prescription drugs, a carrier shall comply with the requirements set forth in subsection 2-B. A provider must make best efforts to provide all information necessary to evaluate a request, and the carrier must make best efforts to limit requests for additional information.

If a carrier does not grant or deny a request for prior authorization within the time frames required under this subsection, the request for prior authorization by the provider is granted and a carrier may not deny payment for a prescription drug dispensed by a pharmacist.

Sec. 6. 24-A MRSA §4304, sub-§2-B, as enacted by PL 2019, c. 273, §2, is amended to read:

2-B. Electronic transmission of prior authorization requests. Beginning no later than January 1, 2020, if a health plan provides coverage for prescription drugs, the carrier must accept and respond to prior authorization requests in accordance with subsection 2 and this subsection through a secure electronic transmission using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. For the purposes of this subsection, transmission of a facsimile through a proprietary payer portal or by use of an electronic form is not considered electronic transmission. A carrier's electronic transmission system for prior authorization requests for prescription drugs must comply with the following.

A. No later than January 1, 2021, a carrier or entity under contract to a carrier shall make available to a provider in real time at the point of prescribing and at the point of dispensing the following information related to each enrollee:

(1) The prescription drug formulary and cost-sharing requirements under the enrollee's health plan;

(2) The prior authorization standards and requirements for the enrollee's health plan;

(3) The cost of the prescription drug requested by the provider and any alternatives to that prescription drug, as appropriate;

(4) Any information on whether there is a financial assistance program available for a prescription drug prescribed by the provider if known by the carrier; and

(5) If the provider's prior authorization request is denied, the reason for the denial and a list of any alternative prescription drugs that the carrier would approve and the cost of those alternatives.

B. The process of accepting and responding to prior authorization requests in real time must be facilitated by a carrier with other carriers, pharmacy benefits managers, health systems, providers, pharmacies and other 3rd parties, including, but not limited to, intermediaries, real-time networks, switches and translation services. To expedite the implementation and adoption of real-time electronic transmission, any such entity must be capable of supporting and using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. Any additional cost to a carrier may not be passed on to an enrollee as a component of the premium.

C. Prescription cost information must be transparent and displayed to a provider at the point of prescribing and must include any options available to the enrollee, including the cost of a prescription drug at the enrollee's pharmacy of choice, the cost of mail order when available, any costs for using a specialty pharmacy if applicable and the cost to the enrollee if the enrollee pays out of pocket.

D. A carrier or a pharmacy benefits manager may not prohibit the display of cost, benefit and coverage information at the point of prescribing that reflects other choices, such as the cost to the enrollee if the enrollee pays out of pocket, financial assistance and support programs if known to the carrier and the cost of a prescription drug at the enrollee's pharmacy of choice.

This subsection may not be construed to interfere with an enrollee's ability to make choices related to prescription drugs. A provider shall communicate with an enrollee about the most therapeutically appropriate treatment for the enrollee's given diagnosis. When appropriate, a provider shall also provide information to an enrollee related to the cost of prescription drugs, including the cost to the enrollee if the enrollee pays out of pocket, alternative prescription drugs and prescription delivery options.

This subsection may not be construed to prohibit the right of an enrollee to choose whether to use the prescription drug coverage available through the enrollee's health plan when obtaining prescription drugs. If an enrollee chooses not to use the enrollee's health plan's prescription drug coverage for a prescription drug being prescribed by a provider, a provider has no obligation to convey this information to the carrier or pharmacy benefits manager.

Sec. 7. Bureau of Insurance to monitor compliance. Beginning January 1, 2021, the Department of Professional and Financial Regulation, Bureau of Insurance shall monitor compliance by carriers authorized to do business in this State with the requirements of the Maine Revised Statutes, Title 24-A, section 4304, subsection 2-B using its authority under Title 24-A, section 221. No later than September 30, 2021, the bureau shall submit a report to the joint standing committee of the Legislature having jurisdiction over health coverage and insurance matters on the status of compliance by carriers. If the bureau determines that a carrier is not complying with the requirements of Title 24-A, section 4304, subsection 2-B, the bureau shall take enforcement action against the carrier as appropriate. The joint standing committee of the Legislature having jurisdiction over health coverage and insurance matters may report out a bill to the Second Regular Session of the 130th Legislature based on the report.

SUMMARY

This bill makes the following changes.

1. It adds a definition of "prior authorization" and clarifies the definitions of "medically necessary health care" and "participating provider" used in the Maine Insurance Code, chapter 56-A.

2. It sets forth additional requirements for carriers to facilitate the processing of prior authorization requests for prescription drugs by providers.