L.D. 705

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HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

SENATE

129TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT " " to S.P. 218, L.D. 705, Bill, "An Act Regarding the Process for Obtaining Prior Authorization for Health Insurance Purposes"

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

'**Sec. 1. 24-A MRSA §4304, sub-§2,** as amended by PL 1999, c. 742, §12, is further amended to read:

2. Prior authorization of nonemergency services. ~~Requests~~ 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. ~~Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.~~

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. 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.

Sec. 2. 24-A MRSA §4304, sub-§§2-A and 2-B are enacted to read:

2-A. Prior authorization of medication-assisted treatment for opioid use disorder. A carrier may not require prior authorization for medication-assisted treatment for opioid use disorder for the prescription of at least one drug for each therapeutic class of medication used in medication-assisted treatment, except that a carrier may not impose any prior authorization requirements on a pregnant woman for medication-assisted treatment for opioid use disorder. For the purposes of this subsection, "medication-assisted treatment" means an evidence-based practice that combines pharmacological interventions with substance use disorder counseling.

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 through a secure electronic transmission using standards 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.

Sec. 3. 24-A MRSA §4311, sub-§1-A, ¶A, as enacted by PL 2019, c. 5, Pt. A, §21, is 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.

Sec. 4. Rulemaking. The Department of Professional and Financial Regulation, Bureau of Insurance shall amend its rule Chapter 850, Health Plan Accountability:

1. To conform to the changes made in this Act; and

2. To replace the term "urgent care" with the term "exigent circumstances" as used in this Act and to change the timeline for review decisions when exigent circumstances exist to no more than 24 hours after receiving the request.

Notwithstanding the Maine Revised Statutes, Title 24-A, section 4309, any rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 5. Report on electronic transmission of prior authorization request for medical services; authorization to report out legislation. No later than

January 1, 2020, health insurance carriers, in cooperation with the Maine Association of Health Plans, shall report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services on efforts to develop standards for secure electronic transmission of prior authorization requests that meet requirements of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. The committee may report out legislation to the Second Regular Session of the 129th Legislature related to the electronic transmission of prior authorization requests for medical services.'

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

SUMMARY

This amendment replaces the bill. The amendment does the following to amend the prior authorization process for health insurance carriers.

1. It reduces the time frame for a carrier's response to a prior authorization request from 2 business days to 72 hours or 2 business days, whichever is less, and clarifies that the same time frame for a response applies in instances when a carrier requests additional information or requires outside consultation. It also provides that a request for prior authorization is granted if a carrier fails to respond within the required time frames.

2. It clarifies a provision in existing law to reflect the change in time frame.

3. It prohibits a carrier from requiring prior authorization for medication-assisted treatment for opioid use disorder for the prescription of at least one drug for each type of medication used in medication-assisted treatment, except that a carrier may not require prior authorization for medication-assisted treatment for opioid use disorder for a pregnant woman.

4. It requires a health insurance carrier to develop an electronic transmission system for prior authorization of prescription drug orders by January 1, 2020.

5. It requires health insurance carriers to report, no later than January 1, 2020, to the Joint Standing Committee on Health Coverage, Insurance and Financial Services on efforts to develop standards for secure electronic transmission of prior authorization requests. It also authorizes the committee to report out legislation to the Second Regular Session of the 129th Legislature related to the electronic transmission of prior authorization requests for medical services.

6. It directs the Department of Professional and Financial Regulation, Bureau of Insurance to amend its rules regarding health plan accountability to conform to the statutory changes and designates those rules as routine technical.