Act No. 111 (H.766). An act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts

Subjects: Health; prescription drugs; health insurance; prior authorization requirements; step therapy; claims edits; cost-sharing collections

This act amends provisions relating to health insurance plans that use step-therapy protocols in their prescription drug coverage and adds a new requirement that plans must grant timely exceptions to their step-therapy protocols under certain circumstances, including when the drug required under the protocol is likely to have adverse effects, to be ineffective, or is not in the patient's best interests, or if the patient is already stable on a different drug for the same condition. The act also requires plans to cover at least one readily available asthma controller medication from each class of medication and mode of administration, without requiring prior authorization.

The act amends provisions relating to how health plans and other payers pay health care claims by limiting the edit standards, processes, and guidelines that can be applied to claims for different types of services; by limiting payers' release of new edits to not more than quarterly and requiring the payers to file the edits with the Department of Financial Regulation (DFR) and provide advance notice of the edits to providers; and by restricting the circumstances under which payers can use prepayment coding validation edit review. The act revives a previous stakeholder working group to look at trends in coding and billing that payers want to address through claim editing; the working group will sunset on January 1, 2028. The act also imposes certain requirements on the content of and processes for issuing and amending policies and manuals that plans use to supplement their contracts with providers, including requiring the plans to provide notice of a new or amended policy or manual to providers and give the providers an opportunity to object.

The act prohibits health plans from imposing prior authorization requirements on any admission, item, service, treatment, or procedure ordered by a primary care provider, except that the prohibition does not apply to prescription drugs or to anything that is provided out-of-network. The act reduces from 48 hours to 24 hours the amount of time a plan has to approve, deny, or ask for more information on an urgent prior authorization request. The act maintains the existing two business-day response requirement for nonurgent prior authorization requests but requires plans to acknowledge the request within 24 hours and to ask at that time for any additional information needed to decide on the request. The act specifies that a prior authorization approval must remain valid for the duration of the prescribed treatment, service, or medication or one year, whichever is longer, and, for a treatment, service, or course of medication that continues for more than one year, the plan cannot require renewal of prior authorization approval more often than once every five years. The act also requires a health plan to allow an insured who changes plans and is stable on a treatment, service, or course of medication approved

under the prior plan to have coverage for that treatment, service, or course of medication without restriction for at least 90 days.

The act directs health insurers and health care providers to report to the General Assembly on or before January 15, 2027, on the impacts of implementation of the prior authorization provisions in the act. For insurers, the report must include the impacts on utilization of services, premium rates, and estimated avoided costs during plan years 2025 and 2026, including the costs of alternative services and hospital visits incurred by insureds as a result of the insurer's denials of their requests for prior authorizations. For health care providers, the report must include information gathered from providers on or before January 1, 2025, and on or before July 1, 2026, in order to evaluate providers' practices and circumstances both before and after the prior authorization provisions took effect.

Multiple effective dates, beginning on May 20, 2024