LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

SECOND SPECIAL SESSION
June 19, 2018 to September 13, 2018

THE GENERAL EFFECTIVE DATE FOR
SECOND SPECIAL SESSION
NON-EMERGENCY LAWS IS
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ONE HUNDRED AND TWENTY-NINTH LEGISLATURE

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TITLE 3, SECTION 163-A, SUBSECTION 4.

Augusta, Maine
2019

CHAPTER 273
S.P. 218 - L.D. 705

An Act Regarding the Process for Obtaining Prior Authorization for Health Insurance Purposes

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

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.

See title page for effective date.

CHAPTER 274
H.P. 594 - L.D. 820

An Act To Prevent Discrimination in Public and Private Insurance Coverage for Pregnant Women in Maine

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

Sec. 1. 22 MRSA §3196 is enacted to read:

§3196. Coverage for non-Medicaid services to MaineCare members

1. Coverage. The department shall provide coverage for abortion services to a MaineCare member.

2. Funding. Abortion services that are not federally approved Medicaid services must be funded by state funds within existing resources.

3. Rulemaking. The department shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. 24 MRSA §2317-B, sub-§20, as amended by PL 2013, c. 575, §3, is further amended to read:

20. Title 24-A, chapters 68 and 68-A. Long-term care insurance, nursing home care insurance and home health care insurance, Title 24-A, chapters 68 and 68-A; ~~and~~

Sec. 3. 24 MRSA §2317-B, sub-§21, as enacted by PL 2013, c. 575, §4 and affected by §10, is amended to read:

21. Title 24-A, sections 2765-A and 2847-U. The practice of dental hygiene by a dental hygiene therapist, Title 24-A, sections 2765-A and 2847-U~~.~~; and

Sec. 4. 24 MRSA §2317-B, sub-§22 is enacted to read:

22. Title 24-A, section 4320-M. Coverage for abortion services, Title 24-A, section 4320-M.

Sec. 5. 24-A MRSA §4320-M is enacted to read:

§4320-M. Coverage for abortion services

1. Required coverage. A carrier offering a health plan in this State that provides coverage for maternity services shall provide coverage for abortion services for an enrollee in accordance with this section.

2. Limits; deductible; copayment; coinsurance. A health plan that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

3. Application. Except for a religious employer granted an exclusion as provided in subsection 4, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

4. Exclusion for religious employer. A religious employer may request and a carrier shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide prospective enrollees and those individuals insured under its policy written notice of the exclusion. This section may not be construed as authorizing a carrier to exclude coverage for abortion services that are necessary to preserve the life or health of a covered enrollee. For the purposes of this section, "religious employer" means an employer that is a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121(w)(3)(A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c)(3).

5. Protection of federal funds. If the superintendent determines enforcement of this section may adversely affect the allocation of federal funds to the