STATE OF MAINE

127TH LEGISLATURE

SECOND REGULAR SESSION

Summaries of bills, adopted amendments and laws enacted or finally passed

JOINT STANDING COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

May 2016

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LEGISLATIVE DIGEST OF BILL SUMMARIES AND ENACTED LAWS

This *Legislative Digest of Bill Summaries and Enacted Laws* contains summaries of all LDs and adopted amendments and all laws enacted or finally passed during the Second Regular Session of the 127th Maine Legislature.

The *Digest* is arranged alphabetically by committee and within each committee by Legislative Document (LD) number. The committee report(s), prime sponsor and lead co-sponsor(s), if designated, are listed below each LD title. All adopted amendments are summarized and listed by paper number. A subject index is included with each committee. An appendix provides a summary of relevant session statistics.

Final action on each LD is noted to the right of the LD title. The following describes the various final actions.

CARRIED OVER.....*carried over to a subsequent session of the Legislature*
CON RES XXX.....*chapter # of constitutional resolution passed by both houses*
CONF CMTE UNABLE TO AGREE..... *Committee of Conference unable to agree; legislation died*
DIED BETWEEN HOUSES.....*House & Senate disagreed; legislation died*
DIED IN CONCURRENCE..... *defeated in each house, but on different motions; legislation died*
DIED ON ADJOURNMENT.....*action incomplete when session ended; legislation died*
EMERGENCY.....*enacted law takes effect sooner than 90 days after session adjournment*
FAILED, EMERGENCY ENACTMENT or PASSAGE.....*emergency failed to receive required 2/3 vote*
FAILED, ENACTMENT or FINAL PASSAGE..... *failed to receive final majority vote*
FAILED, MANDATE ENACTMENT.....*legislation proposing local mandate failed required 2/3 vote*
HELD BY GOVERNOR..... *Governor has not signed; final disposition to be determined at subsequent session*
LEAVE TO WITHDRAW.....*sponsor's request to withdraw legislation granted*
NOT PROPERLY BEFORE THE BODY.....*ruled out of order by the presiding officer; legislation died*
INDEF PP..... *indefinitely postponed; legislation died*
ONTP, ACCEPTED, MAJORITY, MINORITY or REPORT X... *ought-not-to-pass report accepted; legislation died*
P&S XXX.....*chapter # of enacted private & special law*
PUBLIC XXX..... *chapter # of enacted public law*
RESOLVE XXX.....*chapter # of finally passed resolve*
VETO SUSTAINED.....*Legislature failed to override Governor's veto*

The effective date for non-emergency legislation enacted in the First Regular Session of the 127th Legislature is July 29, 2016. The effective date for legislation enacted as an emergency measure may be found in the enacted law summary for that legislation.

LD 704 **An Act Regarding Notice Provided by Insurance Carriers to Health Care Providers** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
BECK H GRATWICK G	ONTP	

This bill was carried over from the First Regular Session of the 127th Legislature.

This bill requires insurance carriers, beginning January 1, 2016, to give health care providers notice that an enrollee covered by an insurance product purchased through the American Health Benefit Exchange is in the three-month grace period under 45 Code of Federal Regulations, Section 156.270(d)(2015).

LD 889 **An Act To Protect Maine's Small Businesses from High Interest Rates on Commercial and Business Loans** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
BECK H KATZ R	ONTP	

This bill was carried over from the First Regular Session of the 127th Legislature.

The bill caps the interest rate for commercial or business loans at 25% per year. The bill provides that violations are subject to criminal penalties of up to $5,000 or imprisonment for not more than one year or both. The bill also allows a court to void a loan issued in violation of the interest rate caps upon the petition of the person to whom the loan was issued.

LD 1150 **An Act Regarding Maximum Allowable Cost Pricing Lists Used by Pharmacy Benefit Managers** **PUBLIC 450**

Sponsor(s)	Committee Report	Amendments Adopted
BROOKS H WHITTEMORE R	OTP-AM	H-556

This bill was reported out of committee and then recommitted to the committee in the prior session; it was then carried over from the First Regular Session of the 127th Legislature.

The bill establishes requirements for maximum allowable cost pricing lists used by pharmacy benefits managers and requires pharmacy benefits managers to make disclosures regarding that pricing and the methods used to establish that pricing to plan sponsors. It establishes an appeal process for pharmacies for disputes relating to maximum allowable cost pricing. The bill also provides for financial penalties for violations.

Committee Amendment "B" (H-556)

This amendment replaces the bill. The amendment establishes certain requirements relating to maximum allowable cost pricing lists used by pharmacy benefits managers.

The amendment provides that a pharmacy benefits manager may set a maximum allowable cost for a prescription drug only if that drug is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange

Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference and the drug is not obsolete and is generally available for purchase in this State.

The amendment requires a pharmacy benefits manager to remove or modify in a timely manner a maximum allowable cost for a prescription drug as necessary for the cost of the prescription drug to remain consistent with changes to such costs and availability of the drug in the national marketplace for prescription drugs.

The amendment requires a pharmacy benefits manager to provide the following to a pharmacy with which the pharmacy benefits manager has a contract:

1. Disclose the sources used to establish the maximum allowable costs used by the pharmacy benefits manager upon request;

2. Provide a process for a pharmacy to readily obtain the maximum allowable reimbursement available to that pharmacy under a maximum allowable cost list; and

3. At least once every seven business days, review and update maximum allowable cost list information to reflect any modification of the maximum allowable reimbursement available to a pharmacy under a maximum allowable cost list used by the pharmacy benefits manager.

The amendment establishes an appeal process to allow a pharmacy to challenge a drug's maximum allowable cost under certain conditions.

The amendment specifies that the provisions apply to contracts between a pharmacy benefits manager and a pharmacy beginning September 1, 2016.

Enacted Law Summary

Public Law 2015, chapter 450 establishes certain requirements relating to maximum allowable cost pricing lists used by pharmacy benefits managers.

The law provides that a pharmacy benefits manager may set a maximum allowable cost for a prescription drug only if that drug is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference and the drug is not obsolete and is generally available for purchase in this State.

The law requires a pharmacy benefits manager to remove or modify in a timely manner a maximum allowable cost for a prescription drug as necessary for the cost of the prescription drug to remain consistent with changes to such costs and availability of the drug in the national marketplace for prescription drugs.

The law requires a pharmacy benefits manager to provide the following to a pharmacy with which the pharmacy benefits manager has a contract:

1. Disclose the sources used to establish the maximum allowable costs used by the pharmacy benefits manager upon request;

2. Provide a process for a pharmacy to readily obtain the maximum allowable reimbursement available to that pharmacy under a maximum allowable cost list; and

3. At least once every seven business days, review and update maximum allowable cost list information to reflect any modification of the maximum allowable reimbursement available to a pharmacy under a maximum allowable

cost list used by the pharmacy benefits manager.

The law also establishes an appeal process to allow a pharmacy to challenge a drug's maximum allowable cost under certain conditions.

Public Law 2015, chapter 450 specifies that the provisions apply to contracts between a pharmacy benefits manager and a pharmacy beginning September 1, 2016.

LD 1305 **An Act To Encourage Health Insurance Consumers To Comparison Shop for Health Care Procedures and Treatment** **Died Between Houses**

Sponsor(s)	Committee Report	Amendments Adopted
WHITTEMORE R	OTP-AM	
BECK H	OTP-AM	

This bill was carried over from the First Regular Session of the 127th Legislature.

This bill requires a health care entity to provide an estimate of the allowed amount if the entity is within a patient's carrier network or the amount that will be charged if the entity does not participate in a patient's carrier network for a proposed admission, procedure or service within two business days of a patient's request and to assist a patient in using a carrier's toll-free telephone number and publicly accessible website to obtain information about the out-of-pocket costs for which a patient will be responsible.

The bill requires health insurance carriers to establish a toll-free telephone number and publicly accessible website to provide information to enrollees about health care costs. A carrier is required to provide information on the average price paid in the past 12 months to a network health care provider for a proposed admission, procedure or service in each geographic rating area established by the carrier and to provide a binding estimate for the maximum allowed amount or charge for a proposed admission, procedure or service and the estimated amount the enrollee will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit.

The bill also requires a carrier to pay an enrollee 50% of the saved cost to a maximum of $7,500 if an enrollee elects to receive health care services from a provider that cost less than the average cost for a particular admission, procedure or service unless the savings is $50 or less. If an enrollee elects to receive health care services from an out-of-network provider that cost less than the average amount for a particular admission, procedure or service, a carrier shall apply the enrollee's share of the cost toward the enrollee's member cost sharing as if the health care services were provided by a network provider.

The bill authorizes a health care entity, a carrier or another person designated by a health care entity, carrier, patient or prospective patient to have access at no cost to the all-payor and all-settings health care database for claims for the purposes of providing the information required.

The bill also requires carriers to provide certain information to the Department of Professional and Financial Regulation, Bureau of Insurance on an annual basis relating to the payments made to enrollees and the saved costs if an enrollee elects to receive health care services from a provider that cost less than the average cost for a particular admission, procedure or service.

Committee Amendment "A" (S-406)

This amendment is the majority report of the committee. The amendment replaces the bill, changes the title and does the following.

The amendment requires a health insurance carrier by January 1, 2018 to establish an interactive mechanism on its