State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 747

02/02/2017 Authored by Hamilton; Zerwas; Dean, M.; Baker; Albright and others
The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform
03/20/2017 By motion, recalled and re-referred to the Committee on Health and Human Services Finance

A bill for an act

relating to health care coverage; modifying prior authorization requirements for prescription drug coverage; requiring prescription drug benefit transparency and disclosure; amending Minnesota Statutes 2016, sections 62M.07; 256B.69, subdivision 6; proposing coding for new law in Minnesota Statutes, chapter 62Q.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2016, section 62M.07, is amended to read:

62M.07 PRIOR AUTHORIZATION OF SERVICES.

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(c) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare or medical assistance.

(d) Any prior authorization for a prescription drug must remain valid for the duration of an enrollee's contract term, except that for the benefits offered under section 256B.69 or chapter 256L, the prior authorization must remain valid for the duration of the enrollee's enrollment or one year, whichever is shorter. These requirements related to the validity of prior authorization apply only if:

(1) the drug continues to be prescribed for a patient with a condition that requires ongoing medication therapy;

(2) the drug has not otherwise been deemed unsafe by the Food and Drug Administration;

(3) the drug has not been withdrawn by the manufacturer or the Food and Drug Administration;

(4) there is no evidence of the enrollee's abuse or misuse of the prescription drug; and

(5) no independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

This paragraph does not apply to individuals assigned to the restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

Sec. 2. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meaning given them.

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract year" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, it means a calendar year beginning January through December.

(d) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees and may include, but is not limited to, procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make its formulary and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's (USP) Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract year:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable

according to the FDA Purple Book at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract year upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract year.

(d) A health plan company may remove any drugs from its formulary that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

Sec. 3. Minnesota Statutes 2016, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must

pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) Managed care plans and county-based purchasing plans must comply with chapter 62M and section 62Q.83.