HOUSE RESEARCH

Bill Summary

File Number: H.F. 747 **Date:** May 16, 2017
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Authors: Hamilton and others

Subject: Utilization Review and Prior Authorization for Prescription Drugs

Analyst: Randall Chun

Overview

This bill contains provisions related to utilization review and prescription drug coverage. The bill:

- specifies the time period for which a prior authorization of a prescription drug by a utilization review organization must remain valid;
- sets disclosure requirements for, and places limits on, formulary changes; and
- requires managed care organizations participating in MA to comply with utilization review organization requirements and requirements related to formulary changes.

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1 **Prior authorization of services.** Amends § 62M.07. Requires any prior authorization by a utilization review organization for a prescription drug to remain valid for the duration of an enrollee's contract term, except that for benefits under MA or MinnesotaCare, the prior authorization must remain valid for the duration of the enrollee's enrollment or one year, whichever is shorter. States that these requirements apply only if:

1) the drug continues to be prescribed for a condition that requires ongoing medication therapy;
2) the drug has not been deemed unsafe by the Food and Drug Administration (FDA);
3) the drug has not been withdrawn by the manufacturer or FDA;

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4) there is no evidence of enrollee abuse or misuse of the drug; and

5) no independent source has issued drug-specific warnings or recommended changes in drug usage.

States that this paragraph does not apply to the restricted recipient program.

2 **Prescription drug benefit transparency and management.** Adds § 62Q.83.

Subd. 1. Definitions. Defines terms.

Subd. 2. Prescription drug benefit disclosure. (a) Requires a health plan company that provides prescription drug coverage and uses a formulary to 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) Requires formularies to be organized and disclosed consistent with the most recent version of the U.S. Pharmacopeia's Model Guidelines.

(c) Requires the specific enrollee benefit terms to be identified for each item or category in the formulary.

Subd. 3. Formulary changes. (a) Allows a health plan company, at any time during a contract year, to expand its formulary, reduce copayments or coinsurance, or move a drug to a category that reduces enrollee costs.

(b) Allows a health plan company to remove a brand name drug from its formulary or place a brand name drug in a category that increases enrollee costs, only if a generic or multisource brand name drug rated as therapeutically equivalent or a biologic drug rated as interchangeable, that has a lower cost to the enrollee, is added to the formulary, upon at least 60 days' notice.

(c) Allows a health plan company to change utilization review requirements or move drugs to a category that increases enrollee costs during a contract year, upon at least 60 days' notice, provided the changes do not apply to enrollees currently taking the drugs for the duration of the enrollee contract year.

(d) Allows a health plan company to remove drugs from its formulary that have been deemed unsafe by the FDA, withdrawn by the FDA or the manufacturer, or when an independent source has issued warnings or recommended changes in usage.

3 **Service delivery.** Amends § 256B.69, subd. 6. Requires managed care and county-based purchasing plans to comply with chapter 62M (utilization review) and section 62Q.83 (drug benefit transparency and management).