

**Maine Bureau of Insurance**  
**Form Filing Review Requirements Checklist**  
**New Laws Effective January 1, 2016**  
**New 9/1/2015**

State Benefit/Provision and/or ACA Requirement	State Law/ Rule and/or Federal Law	State Description of Requirement and/or ACA Description of Requirement	N/A →	CONFIRM COMPLIANCE AND IDENTIFY LOCATION OF STANDARD IN FILING AND EXPLAIN IF REQUIREMENT IS INAPPLICABLE
<b>PRESCRIPTION DRUGS</b>				
Abuse-deterrent opioid analgesic drug products	24-A M.R.S.A. §4320-J	<p>A carrier offering a health plan in this State shall provide coverage for abuse-deterrent opioid analgesic drug products listed on any formulary, preferred drug list or other list of drugs used by the carrier on a basis not less favorable than that for opioid analgesic drug products that are not abuse-deterrent and are covered by the health plan.</p> <p>An increase in enrollee cost sharing to achieve compliance with this section may not be implemented.</p> <p>Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.</p> <p>A. "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration with</p>	<input type="checkbox"/>	

		<p>abuse-deterrent labeling claims that indicate the drug product is expected to result in a meaningful reduction in abuse.</p> <p>B. "Cost sharing" means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense associated with a health plan.</p> <p>C. "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release, long-acting form and whether or not combined with other drug substances to form a single drug product or dosage form.</p>		
Early refills of prescription eye drops	24-A M.R.S.A. §4314-A	<p>A carrier offering a health plan in this State shall provide coverage for one early refill of a prescription for eye drops if the following criteria are met:</p> <p>A. The enrollee requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed;</p> <p>B. The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized;</p> <p>C. The refill requested by the enrollee does not exceed the number of refills indicated on the original prescription;</p> <p>D. The prescription has not been refilled</p>	<input type="checkbox"/>	

		<p>more than once during the period authorized by the prescribing health care provider prior to the request for an early refill; and</p> <p>E. The prescription eye drops are a covered benefit under the enrollee's health plan.</p> <p>2. Cost sharing. A carrier may impose a deductible, copayment or coinsurance requirement for an early refill under this section as permitted under the health plan.</p>		
Information about prescription drugs	24-A MRSA §4303, sub-§20	<p>Consistent with the requirements of the federal Affordable Care Act, a carrier offering a health plan in this State shall provide the following information to prospective enrollees and enrollees with respect to prescription drug coverage on its publicly accessible website.</p> <p>A. A carrier shall post each prescription drug formulary for each health plan offered by the carrier. The prescription drug formularies must be posted in a manner that allows prospective enrollees and enrollees to search the formularies and compare formularies to determine whether a particular prescription drug is covered under a formulary. When a change is made to a formulary, the updated formulary must be posted on the website within 72 hours.</p> <p>B. A carrier shall provide an explanation of:</p> <p>(1) The requirements for utilization review, prior authorization or step therapy for each category of prescription drug covered under a</p>	<input type="checkbox"/>	

		<p>health plan;</p> <p>(2) The cost-sharing requirements for prescription drug coverage, including a description of how the costs of prescription drugs will specifically be applied or not applied to any deductible or out-of-pocket maximum required under a health plan;</p> <p>(3) The exclusions from coverage under a health plan and any restrictions on use or quantity of covered health care services in each category of benefits; and</p> <p>(4) The amount of coverage provided under a health plan for out-of-network providers or noncovered health care services and any right of appeal available to an enrollee when out-of-network providers or noncovered health care services are medically necessary.</p>		
Prescription synchronization	24-A M.R.S.A. §2769	<p>If a health plan provides coverage for prescription drugs, a carrier:</p> <p>A. Shall permit and apply a prorated daily cost-sharing rate to a prescription that is dispensed by a pharmacist in the carrier's network for less than a 30-day supply if the prescriber or pharmacist determines that filling or refilling the prescription for less than a 30-day supply is in the best interest of the patient and the patient requests or agrees to less than a 30-day supply in order to synchronize the refilling of that prescription with the patient's other prescriptions;</p> <p>B. May not deny coverage for the dispensing</p>	<input type="checkbox"/>	

of a medication prescribed for the treatment of a chronic illness that is made in accordance with a plan developed by the carrier, the insured, the prescriber and a pharmacist to synchronize the filling or refilling of multiple prescriptions for the insured. The carrier shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon in order to synchronize the patient's prescriptions; and

C. May not use payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions must be paid in full for each prescription dispensed, regardless of any prorated copay for the insured or fee paid for alignment services.

2. Application; exclusion. The requirements of this section do not apply to a prescription for:

A. Solid oral doses of antibiotics; or

B. Solid oral doses that are dispensed in their original container as indicated in the federal Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist a patient with compliance.