WEST VIRGINIA LEGISLATURE

2016 REGULAR SESSION

Introduced

Senate Bill 273

BY SENATORS FERNS AND STOLLINGS

[Introduced January 14, 2016; Referred

to the Committee on Banking and Insurance; and then to

the Committee on the Judiciary.]

1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section,
2 designated §33-45-2a, relating to required provisions regarding prior authorization of drug
3 benefits by insurers.

Be it enacted by the Legislature of West Virginia:

1 That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new
2 section, designated §33-45-2a, to read as follows:

ARTICLE 45. ETHICS AND FAIRNESS IN INSURER BUSINESS PRACTICES.

§33-45-2a. Insurance contracts; required provisions regarding prior authorization of drug benefits by insurers.

1 (a) As used in this section, unless the context requires a different meaning:
2 (1) "Insurer" has the same meaning ascribed thereto in section two, article one of this
3 chapter.
4 (2) "Chronic disease management drug" means any drug used to treat an insured's
5 chronic, incurable, permanent or recurring medical condition.
6 (3) "Mental health drug" means any drug prescribed to treat an insured's mental disorder,
7 including psychological, behavioral, or emotional disorders.
8 (4) "Prior authorization" means the approval process used by a carrier before certain drug
9 benefits may be provided.
10 (5) "Insurance" has the same meaning ascribed thereto in section one, article one of this
11 chapter.
12 (6) "Step therapy restrictions" means a restriction by a carrier requiring the use of
13 additional steps, such as attempting other drug options, prior to approval of a drug benefit subject
14 to prior authorization.
15 (7) "Supplementation" means an electronic request communicated by the insurer or its
16 intermediary to the provider for additional information, limited to items identified on the applicable
17 prior authorization request form, necessary to approve or deny a prior authorization request.

(8) "Universal prior authorization form" means a form made available by the commissioner for use in prior authorization.

(b) Any provider contract between an insurer and a participating health care provider, or its contracting agent, pursuant to which the insurer has the right or obligation to require prior authorization for a drug benefit, shall contain specific provisions that:

(1) Accept universal prior authorization forms;

(2) Permit the electronic submission of prior authorization requests using methods and systems that are interoperable with e-prescribing systems, electronic health records, and health information exchange platforms. Permitted electronic submission formats shall conform to the National Council for Prescription Drug Programs (NCPDP) SCRIPT standards;

(3) Require prior authorization for chronic disease management drug benefits only when a patient: (i) Is not medically stable on the prescribed drug; or (ii) has not completed prior step therapy restrictions, if required, for the prescribed drug;

(4) Require prior authorization for mental health drug benefits only when a patient: (i) Is not medically stable on the prescribed drug; or (ii) has not completed prior step therapy, if required, for the prescribed drug;

(5) Require that prior authorization approved by another insurer be honored for the initial ninety days of an insured's prescription drug benefit coverage upon the insurer's receipt from the prescriber of record demonstrating the previous insurer's prior authorization approval;

(6) Require that prior authorization requests be deemed to be approved unless the insurer has communicated electronically to the prescriber within forty-eight hours of receipt of the request that it is denied or requires supplementation;

(7) Require that prior authorization requests be deemed to be approved unless the insurer has communicated electronically to the prescriber within twenty-four hours of receipt of supplementation by the prescriber, or his agent, that it is denied;

(8) Require that, if a prior authorization request is approved by the insurer, the prior

44 authorization approval be valid for not less than one year;

45 (9) Require that if the prior authorization request is denied, the insurer shall communicate

46 the reasons for the denial electronically to the prescriber within the periods set forth in subdivisions

47 six and seven;

48 (10) Require that prior authorization of a three-day supply of a prescribed drug be deemed

49 to be approved where delay in filling the prescribed drug could reasonably be expected by a

50 prudent layperson who possesses an average knowledge of health and medicine to result in: (i)

51 Serious jeopardy to the mental, behavioral, emotional, or physical health of the insured; (ii) danger

52 of serious impairment of the insured's bodily functions; (iii) serious dysfunction of any of the

53 insured's bodily organs; or (iv) in the case of a pregnant insured, serious jeopardy to the health

54 of the fetus;

55 (11) Require prior authorization for generic drug benefits only when: (i) The prescribed

56 drug is an opioid; or (ii) when the carrier's cost of reimbursement for the generic drug benefit

57 exceeds its cost of reimbursement for the brand name drug;

58 (12) Require that a tracking number be assigned by the insurer to all prior authorization

59 requests and that the tracking number be provided electronically to the prescriber upon the

60 insurer's receipt of the prior authorization request; and

61 (13) Require that the insurer's prescription drug formularies, all drug benefits subject to

62 prior authorization by the insurer, all of the insurer's prior authorization procedures, and all prior

63 authorization request forms accepted by the insurer be centrally located on the insurer's website

64 and that such postings be updated by the insurer within seven days of approved changes.

65 (c) The provisions of this section are inapplicable where the insurer has evidence of fraud,

66 waste, or abuse by the insured or the prescriber and the insurer has notified the prescriber that

67 the provisions of this section are accordingly inapplicable.

68 (d) The commissioner has no jurisdiction to adjudicate individual controversies arising out

69 of this section.

70 (e) This section applies with respect to any contract between an insurer and a participating
71 health care provider, or its contracting agent, pursuant to which the insurer has the right or
72 obligation to require prior authorization for a drug benefit, that is entered into, amended, extended,
73 or renewed on or after January 1, 2016.
74 (f) That on or before December 1, 2016, and annually thereafter, the West Virginia
75 Academy of Family Physicians, the West Virginia State Medical Association, the American
76 Academy of Pediatrics - West Virginia Chapter, the American College of Physicians - West
77 Virginia Chapter, the West Virginia Psychiatric Association, the West Virginia Pharmacists
78 Association and other appropriate health care provider and insurer stakeholders shall develop,
79 and annually update, universal prior authorization forms. Such forms shall be provided to the
80 Insurance Commissioner in both electronic and nonelectronic formats, shall be disease state
81 specific, shall contain a check box for the provider to enter patient specific information, and shall
82 enable the prescriber to submit a renewal request by marking the form to indicate there has been
83 no change in the patient's condition since the last prior authorization request. The commission
84 shall make the universal prior authorization forms available, in both electronic and nonelectronic
85 formats, on or before January 1, 2017, and shall make revised universal prior authorization forms
86 available annually thereafter.

NOTE: The purpose of this bill is to set forth required provisions regarding prior authorization of drug benefits by insurers.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.