WEST VIRGINIA LEGISLATURE

2019 REGULAR SESSION

Introduced

Senate Bill 5

BY SENATORS TAKUBO, BOSO, STOLLINGS, AND JEFFRIES

[Introduced January 9, 2019; Referred

to the Committee on Health and Human Resources; and

then to the Committee on Finance]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §33-4-24, relating to requiring the Public Employees Insurance Agency, managed care organizations, and private commercial insurers to develop prior authorization forms; providing for electronically transmitted prior authorization forms; establishing procedures for submission and acceptance of forms; establishing form requirements; providing what health care practitioners may submit a prior authorization; providing for a provision for an incomplete submission; providing for an audit; granting enforcement powers to the Insurance Commissioner; setting forth peer review procedures; providing for mandatory medication provisions upon discharge or substation; requiring certain information to be included on the insurers web page and the form; and setting deadlines.

Be it enacted by the Legislature of West Virginia:

ARTICLE 4. GENERAL PROVISIONS.

§33-4-24. Prior authorization.

(a) The Public Employees Insurance Agency, managed care organizations, and private commercial insurers are required to develop prior authorization forms. These forms are required to be placed in an easily identifiable and accessible place on their webpage. The forms shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification confirming receipt of the prior authorization request;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment and anything else for which the insurer requires prior authorization. The standard for including any matter on this list shall be science based using a nationally recognized standard. This list is required to be updated regularly to ensure that the list remains current;

(4) Inform the patient if the insurer requires plan members to use step therapy protocols, as set forth in this chapter. This must be conspicuous on the prior authorization form. If the patient

has completed step therapy as required by the insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by October 1, 2019.

(b) The Public Employees Insurance Agency, managed care organizations, and private commercial insurers shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. An insurer is required to accept an electronically submitted prior authorization submitted by either a physician licensed to practice allopathic medicine pursuant to §30-3-1 *et seq.* of this code, a physician licensed to osteopathic medicine pursuant to §30-14-1 *et seq.* of this code, a physician assistant licensed pursuant to the provisions of §30-3E-1 *et seq.* of this code, or an advance practice registered nurse licensed pursuant to the provisions of §30-7-1 *et seq.* of this code, so long as the request is within the health care practitioners scope of practice.

(c) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the insurer or plan shall respond to the prior authorization request within 24 business hours from the time on the electronic receipt of the prior authorization request, except that the insurer or plan shall respond to the prior authorization request immediately if the request is for a medical care or other service for a condition where application of the time frame for making routine or nonlife-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(d) If information submitted is considered incomplete, the insurer shall immediately return

the prior authorization to the health care provider. The health care practitioner shall provide the additional information requested within 72 hours from the time the request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

(e) If the insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to a personal review.

(f) A prior authorization approved by a managed care organization is carried over to all other managed care organizations for three months, if the services are provided within the state.

(g) The Public Employees Insurance Agency, managed care organizations, and private commercial insurers shall use national practice guidelines to evaluate a prior authorization.

(h) The Insurance commissioner shall have enforcement powers to enforce the provisions of this section, including the ability to administratively fine an insurer who is not compliant. A managed care organization who has a contract to provide services to a state agency who is found by the Insurance commissioner to be excessively noncompliant shall have their contract with the state terminated. All existing patients covered by the contract shall be reallocated among compliant managed care organizations with a state contract.

(i) If a prior authorization is rejected by an insurer and the health care practitioner who submitted the prior authorization requests a peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education and background.

(j) Any prescription written at the time of discharge of a patient shall not be subject to prior authorization requirements and shall be immediately approved for not less than 72 business hours.

(k) If the approval of a prior authorization requires a medication substitution, the substituted medication must be of an equivalent medication class.

(l) The Public Employees Insurance Agency, managed care organizations, and private commercial insurers shall post the percentages of approved and disapproved prior authorization requests in an easily identifiable and accessible place on their webpage. The necessity of a prior

authorization for any procedure, service, drug, device, treatment, durable medical equipment and anything else for which the insurer requires prior authorization, and which are being authorized greater than or equal to 98 per cent of the time, shall be deemed unnecessary and the insurer shall be required to remove it from the prior authorization requirements.

(m) This section is not applicable to submission of a prior authorization request through telephone, mail, or fax.

NOTE: The purpose of this bill is to require the Public Employees Insurance Agency, managed care organizations, and private commercial insurers to develop prior authorization forms. The bill provides for electronically transmitted prior authorization forms. The bill establishes procedures for submission and acceptance of forms. The bill establishes form requirements. The bill provides what health care practitioners may submit a prior authorization. The bill provides for a provision for an incomplete submission. The bill provides for an audit. The bill grants enforcement powers to the Insurance Commissioner. The bill sets forth peer review procedures. The bill provides for mandatory medication provisions upon discharge or substation. The bill requires certain information to be included on the insurers web page and the form. The bill sets deadlines.

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