WEST VIRGINIA LEGISLATURE

2025 REGULAR SESSION

Committee Substitute

for

Senate Bill 833

BY SENATOR CHAPMAN

[Reported March 26, 2025, from the Committee on

Finance]

A BILL to amend and reenact §5-16-7f, §9-5-32, §33-15-4s, §33-16-3dd, §33-24-7s, §33-25-8p,
 and §33-25a-8s of the Code of West Virginia, 1931, as amended, relating to prior
 authorization; and clarifying that pharmaceutical medication if excluded from the prior
 authorization gold card process.

Be it enacted by the Legislature of West Virginia:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7f. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to
 them in this section unless the context clearly indicates otherwise:

3 "Episode of care" means a specific medical problem, condition, or specific illness being 4 managed, including tests, procedures, and rehabilitation initially requested by the health care 5 practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That 6 any additional testing or procedures related or unrelated to the specific medical problem, 7 condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the 9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United 10 States Department of Health and Human Services. Subsequently released versions may be used 11 provided that the new version is backward compatible with the current version approved by the 12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from the Public Employees 14 Insurance Agency regarding the coverage of a service or medication.

15 (b) The Public Employees Insurance Agency shall require prior authorization forms, 16 including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable 17 18 and accessible place on the Public Employees Insurance Agency's webpage and the portal web 19 address shall be included on the insured's insurance card. The portal shall:

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

21 (2) Provide an electronic notification to the health care provider confirming receipt of the 22 prior authorization request for forms submitted electronically;

23 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, 24 durable medical equipment, and anything else for which the Public Employees Insurance Agency 25 requires a prior authorization. The standard for including any matter on this list shall be science-26 based using a nationally recognized standard. This list shall be updated at least guarterly to 27 ensure that the list remains current;

28 (4) Inform the patient if the Public Employees Insurance Agency requires a plan member 29 to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the 30 patient has completed step therapy as required by the Public Employees Insurance Agency and 31 the step therapy has been unsuccessful, this shall be clearly indicated on the form, including 32 information regarding medication or therapies which were attempted and were unsuccessful; and 33

(5) Be prepared by July 1, 2024.

34 (c) The Public Employees Insurance Agency shall provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider. 35 36 (d) After the health care practitioner submits the request for prior authorization 37 electronically, and all of the information as required is provided, the Public Employees Insurance 38 Agency shall respond to the prior authorization request within five business days from the day on

39 the electronic receipt of the prior authorization request: *Provided*, That the Public Employees 40 Insurance Agency shall respond to the prior authorization request within two business days if the 41 request is for medical care or other service for a condition where application of the time frame for 42 making routine or non-life-threatening care determinations is either of the following:

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

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

48 (e) If the information submitted is considered incomplete, the Public Employees Insurance 49 Agency shall identify all deficiencies, and within two business days from the day on the electronic 50 receipt of the prior authorization, request return the prior authorization to the health care 51 practitioner. The health care practitioner shall provide the additional information requested within 52 three business days from the day the return request is received by the health care practitioner. 53 The Public Employees Insurance Agency shall render a decision within two business day after 54 receipt of the additional information submitted by the health care provider. If the health care 55 practitioner fails to submit additional information, the prior authorization is considered denied and 56 a new request shall be submitted.

(f) If the Public Employees Insurance Agency wishes to audit the prior authorization or if
the information regarding step therapy is incomplete, the prior authorization may be transferred
to the peer review process within two business days from the day on the electronic receipt of the
prior authorization request.

(g) A prior authorization approved by the Public Employees Insurance Agency is carried
over to all other managed care organizations and health insurers for three months if the services
are provided within the state.

64 (h) The Public Employees Insurance Agency shall use national best practice guidelines to65 evaluate a prior authorization.

66 (i) If a prior authorization is rejected by the Public Employees Insurance Agency and the 67 health care practitioner who submitted the prior authorization requests an appeal by peer review 68 of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, 69 education, and background. The Public Employees Insurance Agency's medical director has the 70 ultimate decision regarding the appeal determination and the health care practitioner has the 71 option to consult with the medical director after the peer-to-peer consultation. Time frames 72 regarding this peer-to-peer appeal process shall take no longer than five business days from the 73 date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a 74 decision on a prior authorization shall take no longer than 10 business days from the date of the 75 appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
authorization may not be subject to prior authorization requirements and shall be immediately
approved for not less than three days: *Provided*, That the cost of the medication does not exceed
\$5,000 per day and the health care practitioner shall note on the prescription or notify the
pharmacy that the prescription is being provided at discharge. After the three-day time frame, a
prior authorization shall be obtained.

82 (2) If the approval of a prior authorization requires a medication substitution, the
83 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

(k) If a health care practitioner has performed an average of 30 procedures per year and
in a six-month time period during that year has received a 90 percent final prior approval rating,
the Public Employees Insurance Agency shall not require the health care practitioner to submit a
prior authorization for at least the next six months, or longer if the Public Employees Insurance
Agency allows: *Provided*, That at the end of the six-month time frame, or longer if the Public

89 Employees Insurance Agency allows, the exemption shall be reviewed prior to renewal. If 90 approved, the renewal shall be granted for a time period equal to the previously granted time 91 period, or longer if the Public Employees Insurance Agency allows. This exemption is subject to 92 internal auditing, at any time, by the Public Employees Insurance Agency and may be rescinded 93 if the Public Employees Insurance Agency determines the health care practitioner is not performing services or procedures in conformity with the Public Employees Insurance Agency's 94 95 benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies 96 based upon the results of the Public Employees Insurance Agency's internal audit. The Public 97 Employees Insurance Agency shall provide a health care practitioner with a letter detailing the 98 rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to 99 prohibit the Public Employees Insurance Agency from requiring a prior authorization for an 100 experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network 101 service or procedure.

(I) This section is effective for policy, contract, plans, or agreements beginning on or after
January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for revocation.

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(n) The Insurance Commissioner may assess a civil penalty for a violation of this section.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-32. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to
 them in this section unless the context clearly indicates otherwise:

3 "Episode of care" means a specific medical problem, condition, or specific illness being 4 managed, including tests, procedures, and rehabilitation initially requested by the health care 5 practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That 6 any additional testing or procedures related or unrelated to the specific medial problem, condition, 7 or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the 9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United 10 States Department of Health and Human Services. Subsequently released versions may be used 11 provided that the new version is backward compatible with the current version approved by the 12 United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from the Bureau for Medical
Services about the coverage of a service or medication.

(b) The Bureau for Medical Services shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the Bureau for Medical Services' webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

(2) Provide an electronic notification to the health care provider confirming receipt of the
 prior authorization request for forms submitted electronically;

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

(4) Inform the patient if the Bureau for Medical Services requires a plan member to use
step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient
has completed step therapy as required by the Bureau for Medical Services 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

33 (5) Be prepared by July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior
 35 authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization 37 electronically, and all of the information as required is provided, the Bureau of Medical Services 38 shall respond to the prior authorization request within five business days from the day on the 39 electronic receipt of the prior authorization request, except that the Bureau of Medical Services 40 shall respond to the prior authorization request within two business days if the request is for 41 medical care or other service for a condition where application of the time frame for making routine 42 or non-life-threatening care determinations is either of the following:

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

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

48 (e) If the information submitted is considered incomplete, the Bureau for Medical Services 49 shall identify all deficiencies, and within two business days from the day on the electronic receipt 50 of the prior authorization request, return the prior authorization to the health care practitioner. The 51 health care practitioner shall provide the additional information requested within three business 52 days from the day the return request is received by the health care practitioner. The Bureau for 53 Medical Services shall render a decision within two business days after receipt of the additional 54 information submitted by the health care provider. If the health care practitioner fails to submit 55 additional information, the prior authorization is considered denied and a new request shall be 56 submitted.

(f) If the Bureau for Medical Services wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by the Bureau for Medical Services is carried over to all
other managed care organizations and health insurers for three months if the services are
provided within the state.

64 (h) The Bureau for Medical Services shall use national best practice guidelines to evaluate65 a prior authorization.

66 (i) If a prior authorization is rejected by the Bureau for Medical Services and the health 67 care practitioner who submitted the prior authorization requests an appeal by peer review of the 68 decision to reject, the peer review shall be with a health care practitioner, similar in specialty, 69 education, and background. The Bureau for Medical Services' medical director has the ultimate 70 decision regarding the appeal determination and the health care practitioner has the option to 71 consult with the medical director after the peer-to-peer consultation. Time frames regarding this 72 peer-to-peer appeal process shall take no longer than five business days from the date of the 73 request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a

prior authorization shall take no longer than 10 business days from the date of the appealsubmission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
authorization may not be subject to prior authorization requirements and shall be immediately
approved for not less than three days: *Provided*, That the cost of the medication does not exceed
\$5,000 per day and the health care practitioner shall note on the prescription or notify the
pharmacy that the prescription is being provided at discharge. After the three-day time frame, a
prior authorization shall be obtained.

82 (2) If the approval of a prior authorization requires a medication substitution, the
83 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

84 (k) If a health care practitioner has performed an average of 30 procedures per year and 85 in a six-month time period during that year has received a 90 percent final prior approval rating, 86 the Bureau for Medical Services may not require the health care practitioner to submit a prior 87 authorization for at least the next six months or longer if the Bureau for Medical Services allows: 88 Provided, That at the end of the six-month time frame, or longer if the Bureau for Medical Services 89 allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted 90 for a time period equal to the previously granted time period, or longer if the Bureau for Medical 91 Services allows. This exemption is subject to internal auditing at any time by the Bureau for 92 Medical Services and may be rescinded if the Bureau for Medical Services determines the health 93 care practitioner is not performing services or procedures in conformity with the Bureau for 94 Medical Services' benefit plan, it identifies substantial variances in historical utilization or identifies other anomalies based upon the results of the Bureau for Medical Services' internal audit. The 95 96 Bureau for Medical Services shall provide a health care practitioner with a letter detailing the 97 rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to 98 prohibit the Bureau for Medical Services from requiring a prior authorization for an experimental

99 treatment, non-covered benefit, <u>pharmaceutical medication</u>, or any out-of-network service or
100 procedure.

(I) This section is effective for policy, contract, plans, or agreements beginning on or after
January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
or after the effective date of this section.

(m) The Inspector General shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations appealed by health are providers, the total number of prior authorizations approved after appeal by health providers, the name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for revocation.

(n) The Inspector General may assess a civil penalty for a violation of this section.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4s. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to
 them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being
managed including tests, procedures, and rehabilitation initially requested by the health care
practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That
any additional testing or procedures related or unrelated to the specific medical problem,
condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from a health insurer about the14 coverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

(2) Provide an electronic notification to the health care provider confirming receipt of the
 prior authorization request for forms submitted electronically;

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

(4) Inform the patient if the health insurer requires a plan member to use step therapy
protocols as set forth in this chapter. This shall be conspicuous on the prior authorization form. If
the patient has completed step therapy as required by the health 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

33 (5) Be prepared by July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior
 35 authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization 37 electronically, and all of the information as required is provided, the health insurer shall respond 38 to the prior authorization request within five business days from the day on the electronic receipt 39 of the prior authorization request, except that the health insurer shall respond to the prior 40 authorization request within two business days if the request is for medical care or other service 41 for a condition where application of the time frame for making routine or non-life-threatening care 42 determinations is either of the following:

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

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

48 (e) If the information submitted is considered incomplete, the health insurer shall identify 49 all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request return the prior authorization to the health care practitioner. The health care 50 51 practitioner shall provide the additional information requested within three business days from the 52 time the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the 53 54 health care provider. If the health care provider fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted. 55

(f) If the health insurer wishes to audit the prior authorization or if the information regarding
step therapy is incomplete, the prior authorization may be transferred to the peer review process
within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a health insurer is carried over to all other managed
care organizations, health insurers, and the Public Employees Insurance Agency for three months
if the services are provided within the state.

62 (h) The health insurer shall use national best practice guidelines to evaluate a prior63 authorization.

64 (i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, 65 the peer review shall be with a health care practitioner, similar in specialty, education, and 66 67 background. The health insurer's medical director has the ultimate decision regarding the appeal 68 determination and the health care practitioner has the option to consult with the medical director 69 after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall 70 take no longer than five business days from the date of the request of the peer-to-peer 71 consultation. Time frames regarding the appeal of a decision on a prior authorization shall take 72 no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
authorization may not be subject to prior authorization requirements and shall be immediately
approved for not less than three days: *Provided*, That the cost of the medication does not exceed
\$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
prescription is being provided at discharge. After the three-day time frame, a prior authorization
shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the
substituted medication shall be as required under §30-5-1 *et seq.* of this code.

(k) If a health care practitioner has performed an average of 30 procedures per year and
in a six-month time period during that year has received a 90 percent final prior approval rating,
the health insurer may not require the health care practitioner to submit a prior authorization for
at least the next six months, or longer if the insurer allows: *Provided*, That at the end of the six-

85 month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time 86 87 period, or longer if the insurer allows. This exemption is subject to internal auditing, at any time, 88 by the health insurer and may be rescinded if the health insurer determines the health care 89 practitioner is not performing services or procedures in conformity with the health insurer's benefit 90 plan, it identifies substantial variances in historical utilization, or identifies other anomalies based 91 upon the results of the health insurer's internal audit. The insurer shall provide a health care 92 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in 93 this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an 94 experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network 95 service or procedure.

96 (I) This section is effective for policy, contract, plans, or agreements beginning on or after
97 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
98 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
99 or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for revocation.

107 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
108 pursuant to §33-3-11 of this code.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3dd. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to
 them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being
managed including tests, procedures, and rehabilitation initially requested by the health care
practitioner to be performed at the site of service, excluding out-of-network care: *Provided*, That
any additional testing or procedures related or unrelated to the specific medical problem,
condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health insurer about thecoverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

(2) Provide an electronic notification to the health care provider confirming receipt of the
 prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
durable medical equipment, and anything else for which the health insurer requires a prior
authorization. The standard for including any matter on this list shall be science-based using a

nationally recognized standard. This list shall be updated at least quarterly to ensure that the list
remains current;

(4) Inform the patient if the health insurer requires a plan member to use step therapy
protocols. This shall be conspicuous on the prior authorization form. If the patient has completed
step therapy as required by the health 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 July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior
 35 authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization 37 electronically, and all of the information as required is provided, the health insurer shall respond 38 to the prior authorization request within five business days from the day on the electronic receipt 39 of the prior authorization request: *Provided*, That the health insurer shall respond to the prior 40 authorization request within two business days if the request is for medical care or other service 41 for a condition where application of the time frame for making routine or non-life-threatening care 42 determinations is either of the following:

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

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

(e) If the information submitted is considered incomplete, the health insurer shall identify
all deficiencies, and within two business days from the day on the electronic receipt of the prior
authorization request, return the prior authorization to the health care practitioner. The health care
practitioner shall provide the additional information requested within three business days from the

time the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding
step therapy is incomplete, the prior authorization may be transferred to the peer review process
within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a managed care organization is carried over to health
insurers, the Public Employees Insurance Agency, and all other managed care organizations for
three months if the services are provided within the state.

62 (h) The health insurer shall use national best practice guidelines to evaluate a prior63 authorization.

64 (i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, 65 66 the peer review shall be with a health care practitioner, similar in specialty, education, and 67 background. The health insurer's medical director has the ultimate decision regarding the appeal 68 determination and the health care practitioner has the option to consult with the medical director 69 after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall 70 take no longer than five business days from the date of request of the peer-to-peer consultation. 71 Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 72 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
authorization may not be subject to prior authorization requirements and shall be immediately
approved for not less than three days: *Provided*, That the cost of the medication does not exceed
\$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the

prescription is being provided at discharge. After the three-day time frame, a prior authorizationshall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the
substituted medication shall be as required under §30-5-1 *et seq.* of this code.

81 (k) If a health care practitioner has performed an average of 30 procedures per year and 82 in a six-month time period during that year has received a 90 percent final prior approval rating. 83 the health insurer may not require the health care practitioner to submit a prior authorization for 84 at least the next six months, or longer if the insurer allows: Provided, That, at the end of the six-85 month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time 86 87 period, or longer if the insurer allows. This exemption is subject to internal auditing by the health 88 insurer at any time and may be rescinded if the health insurer determines the health care 89 practitioner is not performing services or procedures in conformity with the health insurer's benefit 90 plan, it identifies substantial variances in historical utilization, or identifies or anomalies based 91 upon the results of the health insurer's internal audit. The insurer shall provide a health care 92 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in 93 this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network 94 95 service or procedure.

96 (I) This section is effective for policy, contract, plans, or agreements beginning on or after
97 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
98 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
99 or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often
as needed, to oversee compliance with this article. The data shall include, but not be limited to,
prior authorizations requested by health care providers, the total number of prior authorizations

denied broken down by health care provider, the total number of prior authorizations appealed by
health care providers, the total number of prior authorizations approved after appeal by health
care providers, the name of each gold card status physician, and the name of each physician
whose gold card status was revoked and the reason for revocation.

107 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
108 pursuant to §33-3-11 of this code.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-7s. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to
 them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being
managed including tests, procedures, and rehabilitation initially requested by the health care
practitioner to be performed at the site of service, excluding out-of-network care: *Provided*, That
any additional testing or procedures related or unrelated to the specific medical problem,
condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health insurer about thecoverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

(2) Provide an electronic notification to the health care provider confirming receipt of the
 prior authorization request for forms submitted electronically;

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

(4) Inform the patient if the health insurer requires a plan member to use step therapy
protocols. This shall be conspicuous on the prior authorization form. If the patient has completed
step therapy as required by the health 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, July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior
 35 authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization 37 electronically, and all of the information as required is provided, the health insurer shall respond 38 to the prior authorization request within five business days from the day on the electronic receipt 39 of the prior authorization request: *Provided*, That the health insurer shall respond to the prior 40 authorization request within two business days if the request is for medical care or other service

for a condition where application of the time frame for making routine or non-life-threatening care
determinations is either of the following:

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

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

48 (e) If the information submitted is considered incomplete, the health insurer shall identify 49 all deficiencies, and within two business days from the day on the electronic receipt of the prior 50 authorization request return the prior authorization to the health care practitioner. The health care 51 practitioner shall provide the additional information requested within three business days from the 52 day the return request is received by the health care practitioner. The health insurer shall render 53 a decision within two business days after receipt of the additional information submitted by the 54 health care provider. If the health care provider fails to submit additional information, the prior 55 authorization is considered denied and a new request shall be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding
step therapy is incomplete, the prior authorization may be transferred to the peer review process
within two business days from the day on the electronic receipt of the prior authorization request.
(g) A prior authorization approved by a health insurer is carried over to all other managed
care organizations, health insurers, and the Public Employees Insurance Agency for three months
if the services are provided within the state.

62 (h) The health insurer shall use national best practice guidelines to evaluate a prior63 authorization.

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

background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
authorization may not be subject to prior authorization requirements and shall be immediately
approved for not less than three days: *Provided*, That the cost of the medication does not exceed
\$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
prescription is being provided at discharge. After the three-day time frame, a prior authorization
shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the
substituted medication shall be as required under §30-5-1 *et seq.* of this code.

81 (k) If a health care practitioner has performed an average of 30 procedures per year and 82 in a six-month time period during that year has received a 90 percent final prior approval rating, 83 the health insurer may not require the health care practitioner to submit a prior authorization for 84 at least the next six months, or longer if the insurer allows: Provided, That, at the end of the six-85 month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, this renewal, shall be granted for a time period equal to the previously granted time 86 87 period, or longer if the insurer allows. This exemption is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health insurer determines the health care 88 89 practitioner is not performing services or procedures in conformity with the health insurer's benefit 90 plan, it identifies substantial variances in historical utilization or identifies other anomalies based 91 upon the results of the health insurer's internal audit. The insurer shall provide a health care 92 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in

this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an
experimental treatment, non-covered benefit, <u>pharmaceutical medication</u>, or any out-of-network
service or procedure.

96 (I) This section is effective for policy, contract, plans, or agreements beginning on or after
97 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
98 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
99 or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician whose gold card status was revoked and the reason for revocation.

107 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
108 pursuant to §33-3-11 of this code.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8p. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to
 them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being
managed including tests, procedures, and rehabilitation initially requested by the health care
practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That
any additional testing or procedures related or unrelated to the specific medical problem,
condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from a health insurer about the14 coverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. These forms shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

(2) Provide an electronic notification to the health care provider confirming receipt of the
 prior authorization request for forms submitted electronically;

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

(4) Inform the patient if the health insurer requires a plan member to use step therapy
protocols. This shall be conspicuous on the prior authorization form. If the patient has completed
step therapy as required by the health 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

33 (5) Be prepared by July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior
 35 authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization 37 electronically, and all of the information as required is provided, the health insurer shall respond 38 to the prior authorization request within five business days from the day on the electronic receipt 39 of the prior authorization request: *Provided*, That the health insurer shall respond to the prior 40 authorization request within two business days if the request is for medical care or other service 41 for a condition where application of the time frame for making routine or non-life-threatening care 42 determinations is either of the following:

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

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

48 (e) If the information submitted is considered incomplete, the health insurer shall identify 49 all deficiencies, and within two business days from the day on the electronic receipt of the prior 50 authorization request, return the prior authorization to the health care practitioner. The health care 51 practitioner shall provide the additional information requested within three business days from the 52 day the return request is received by the health care practitioner. The health insurer shall render 53 a decision within two business days after receipt of the additional information submitted by the 54 health care provider. If the health care provider fails to submit additional information the prior authorization is considered denied and a new request shall be submitted. 55

(f) If the health insurer wishes to audit the prior authorization or if the information regarding
step therapy is incomplete, the prior authorization may be transferred to the peer review process
within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a health insurer is carried over to all other managed
care organizations, health insurers, and the Public Employees Insurance Agency for three months
if the services are provided within the state.

62 (h) The health insurer shall use national best practice guidelines to evaluate a prior63 authorization.

64 (i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, 65 the peer review shall be with a health care practitioner, similar in specialty, education, and 66 67 background. The health insurer's medical director has the ultimate decision regarding the appeal 68 determination and the health care practitioner has the option to consult with the medical director 69 after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall 70 take no longer than five business days from the date of the request of the peer-to-peer 71 consultation. Time frames regarding the appeal of a decision on a prior authorization shall take 72 no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
authorization may not be subject to prior authorization requirements and shall be immediately
approved for not less than three days: *Provided*, That the cost of the medication does not exceed
\$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
prescription is being provided at discharge. After the three-day time frame, a prior authorization
shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the
substituted medication shall be as required under §30-5-1 *et seq.* of this code.

(k) If a health care practitioner has performed an average of 30 procedures per year and
in a six-month time period during that year has received a 90 percent final prior approval rating,
the health insurer may not require the health care practitioner to submit a prior authorization for

84 at least the next six months, or longer if the insurer allows: Provided. That, at the end of the six-85 month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. 86 If approved, the renewal shall be granted for a time period equal to the previously granted time 87 period, or longer is the insurer allows. This exemption is subject to internal auditing, at any time, 88 by the health insurer and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit 89 90 plan, it identifies substantial variance in historical utilization, or other anomalies based upon the 91 results of the health insurer's internal audit. The insurer shall provide a health care practitioner 92 with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection 93 may be interpreted to prohibit an insurer from requiring a prior authorization for an experimental 94 treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or 95 procedure.

96 (I) This section is effective for policy, contract, plans, or agreements beginning on or after
97 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
98 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
99 or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician whose gold card status was revoked and the reason for revocation.

107 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
108 pursuant to §33-3-11 of this code.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8s. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to
 them in this section unless the context clearly indicates otherwise:

3 "Episode of care" means a specific medical problem, condition, or specific illness being 4 managed including tests, procedures, and rehabilitation initially requested by the health care 5 practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That 6 any additional testing or procedures related or unrelated to the specific medical problem, 7 condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the 9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United 10 States Department of Health and Human Services. Subsequently released versions may be used 11 provided that the new version is backward compatible with the current version approved by the 12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from a health maintenance14 organization about the coverage of a service or medication.

(b) The health maintenance organization shall require prior authorization forms, including
any related communication, to be submitted via an electronic portal and shall accept one prior
authorization for an episode of care. These forms shall be placed in an easily identifiable and
accessible place on the health maintenance organization's webpage and the portal web address
shall be included on the insured's insurance card. The portal shall:

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

(2) Provide an electronic notification to the health care provider confirming receipt of the
 prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
durable medical equipment, and anything else for which the health maintenance organization
requires a prior authorization. The standard for including any matter on this list shall be sciencebased using a nationally recognized standard. This list shall be updated at least quarterly to
ensure that the list remains current;

(4) Inform the patient if the health maintenance organization requires a plan member to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health maintenance organization 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 July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior
 35 authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization 37 electronically, and all of the information as required is provided, the health maintenance 38 organization shall respond to the prior authorization request within five business days from the 39 day on the electronic receipt of the prior authorization request, except that the health maintenance 40 organization shall respond to the prior authorization request within two business days if the 41 request is for medical care or other service for a condition where application of the time frame for 42 making routine or non-life-threatening care determinations is either of the following:

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

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

48 (e) If the information submitted is considered incomplete, the health maintenance 49 organization shall identify all deficiencies, and within two business days from the day on the 50 electronic receipt of the prior authorization request, return the prior authorization to the health 51 care practitioner. The health care practitioner shall provide the additional information requested 52 within three business days from the day the return request is received by the health care 53 practitioner. The health insurer shall render a decision within two business days after receipt of 54 the additional information submitted by the health care provider. If the health care provider fails to submit the additional information, the prior authorization is considered denied and a new 55 56 request shall be submitted.

57 (f) If the health maintenance organization wishes to audit the prior authorization or if the 58 information regarding step therapy is incomplete, the prior authorization may be transferred to the 59 peer review process within two business days from the day on the electronic receipt of the prior 60 authorization request.

(g) A prior authorization approved by a health maintenance organization is carried over to
all other managed care organizations, health insurers, and the Public Employees Insurance
Agency for three months if the services are provided within the state.

64 (h) The health maintenance organization shall use national best practice guidelines to65 evaluate a prior authorization.

(i) If a prior authorization is rejected by the health maintenance organization and the health
care practitioner who submitted the prior authorization requests an appeal by peer review of the
decision to reject, the peer review shall be with a health care practitioner, similar in specialty,
education, and background. The health maintenance organization's medical director has the
ultimate decision regarding the appeal determination and the health care practitioner has the

option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
authorization may not be subject to prior authorization requirements and shall be immediately
approved for not less than three days: *Provided*, That the cost of the medication does not exceed
\$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
prescription is being provided at discharge. After the three-day time frame, a prior authorization
shall be obtained.

82 (2) If the approval of a prior authorization requires a medication substitution, the
83 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

84 (k) If a health care practitioner has performed an average of 30 procedures per year and 85 in a six-month time period during that year has received a 90 percent final prior approval rating, 86 the health maintenance organization may not require the health care practitioner to submit a prior 87 authorization for at least the next six months or longer if the insurer allows: Provided, That at the 88 end of the six-month time frame, or longer if the insurer allows, the exemption shall be reviewed 89 prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the insurer allows. This exemption is subject to internal auditing, 90 91 at any time, by the health maintenance organization and may be rescinded if the health 92 maintenance organization determines the health care practitioner is not performing services or 93 procedures in conformity with the health maintenance organization's benefit plan, it identifies 94 substantial variances in historical utilization, or identifies other anomalies based upon the results 95 of the health maintenance organization's internal audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in 96

97 this subsection may be interpreted to prohibit an insurer from requiring prior authorization for an 98 experimental treatment, non-covered benefit, or any out-of-network service or procedure. This 99 subsection shall not apply to <u>pharmaceutical medications or</u> services or procedures where the 100 benefit maximums or minimums have been required by statute or policy of the Bureau for Medical 101 Services as it relates to the Medicaid Program.

(I) This section is effective for policy, contract, plans, or agreements beginning on or after
January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on
or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician whose gold card status was revoked and the reason for revocation.

(n) The Insurance Commissioner may assess a civil penalty for a violation of this section
pursuant to §33-3-11 of this code.