WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

Senate Bill 822

By Senator Helton

[Introduced February 6, 2026; referred

to the Committee on Health and Human Resources;

and then to 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 authorizations; defining terms; revising gold card process to include hospitals or departments of hospitals; revising criteria to qualify for a gold card; extending time frame gold card is effective; establishing new effective date; revising data-reporting requirements; permitting provider to request that the Office of the Insurance Commissioner provide data related to performance metrics used to determine his or her gold card status; requiring the Office of the Insurance Commissioner to standardize the gold carding process; and increasing the civil penalty for violations.

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:

"Episode of care" means a specific medical problem, condition, or specific illness being managed, including tests, imaging, 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.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the

NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from the Public Employees Insurance Agency regarding the coverage of a service or medication with a cost over $10,000.

(b) The Public Employees Insurance Agency 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 Public Employees Insurance Agency's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(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 Public Employees Insurance Agency 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 Public Employees Insurance Agency 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 Public Employees Insurance Agency 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.

(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.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the Public Employees Insurance Agency shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the Public Employees Insurance Agency shall respond to the prior 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:

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

(e) If the information submitted is considered incomplete, the Public Employees Insurance Agency 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 day the return request is received by the health care practitioner. The Public Employees Insurance Agency shall render a decision within two business day after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information, the prior authorization is considered denied and 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.

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

(i) If a prior authorization is rejected by the Public Employees Insurance Agency 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 Public Employees Insurance Agency'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 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.

(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, hospital, or department within a hospital has ~~performed an average of 30 procedures~~ submitted at least 10 prior authorizations 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, hospital, or department within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months, or longer if the Public Employees Insurance Agency allows: *Provided*, That at the end of the ~~six~~ 12-month time frame, or longer if the Public Employees Insurance Agency allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the Public Employees Insurance Agency allows. This exemption is subject to internal auditing, at any time, by the Public Employees Insurance Agency and may be rescinded 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 benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the Public Employees Insurance Agency's internal audit. The Public Employees Insurance Agency shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit the Public Employees Insurance Agency from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, ~~2024~~ 2027. 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 approved after appeal by health care

providers, the name of each gold card status physician, hospital, or department within a hospital and the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

(n) If a health care practitioner, hospital, or department within a hospital believes it qualifies for gold card status, but has not yet been awarded, it may request from the West Virginia Office of the Insurance Commissioner (OIC) the underlying source data and performance metrics used to determine his or her gold card status. The OIC shall provide this information within 24 hours of the request.

(o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall implement a standardized gold carding process for all payors.

(p) The Insurance Commissioner may assess a civil penalty of up to $10,000 for a per 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:

"Episode of care" means a specific medical problem, condition, or specific illness being managed, including tests, imaging, 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 medial problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the

NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the 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 with a cost of $10,000.

(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:

(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

(5) Be prepared by July 1, 2024.

(c) Provide electronic communication via the portal regarding the current status of the prior

authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the Bureau of Medical Services shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request, except that the Bureau of Medical Services shall respond to the prior 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:

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

(e) If the information submitted is considered incomplete, the Bureau for Medical Services 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 day the return request is received by the health care practitioner. The Bureau for Medical Services shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information, the prior authorization is considered denied and a new request shall be 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.

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

(i) If a prior authorization is rejected by the Bureau for Medical Services 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 Bureau for Medical Services' 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 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.

(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, hospital, or department within a hospital has ~~performed an average of 30 procedures~~ submitted at least 10 prior authorizations per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the Bureau for Medical Services may not require the health care practitioner, hospital, or department within a

hospital to submit a prior authorization for at least the next ~~six~~ 12 months or longer if the Bureau for Medical Services allows: *Provided*, That at the end of the ~~six~~ 12-month time frame, or longer if the Bureau for Medical Services allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the Bureau for Medical Services allows. This exemption is subject to internal auditing at any time by the Bureau for Medical Services and may be rescinded if the Bureau for Medical Services determines the health care practitioner is not performing services or procedures in conformity with the Bureau for 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 Bureau for Medical Services shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit the Bureau for Medical Services from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, ~~2024~~ 2027. 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 approved after appeal by health care providers, the name of each gold card status physician, hospital, or department within a hospital and the name of each physician, hospital, or department within a hospital whose gold card status

was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

(n) If a health care practitioner, hospital, or department within a hospital believes it qualifies for gold card status, but has not yet been awarded, it may request from the Inspector General the underlying source data and performance metrics used to determine his or her gold card status. The OIC shall provide this information within 24 hours of the request.

(o) By January 1, 2027, the Inspector General shall implement a standardized gold carding process.

(p) The Inspector General may assess a civil penalty of up to $10,000 per 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, imaging, 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.

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

United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication with a cost of over $10,000.

(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:

(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

(5) Be prepared by July 1, 2024.

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

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to

the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior 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:

(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 health care practitioner with knowledge of the patient's medical condition would subject the patient to adverse health consequences without the care or treatment 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 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.

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

(k) If a health care practitioner, hospital, or department within a hospital has ~~performed an average of 30 procedures~~ submitted at least 10 prior authorizations 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, hospital, or department within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months, or longer if the insurer allows: *Provided*, That at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. 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, at any time, 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 plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the health insurer'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 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 service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, ~~2024~~ 2027. 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 approved after appeal by health care providers, the name of each gold card status physician, hospital, or department within a hospital and the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

(n) If a health care practitioner, hospital, or department within a hospital believes it qualifies for gold card status, but has not yet been awarded, it may request from the West Virginia Office of the Insurance Commissioner (OIC) the underlying source data and performance metrics used to

determine his or her gold card status. The OIC shall provide this information within 24 hours of the request.

(o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall implement a standardized gold carding process for all payors.

(p) The Insurance Commissioner may assess a civil penalty of up to $10,000 per violation of this section.

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, imaging, 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.

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

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication with a cost of $10,000.

(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:

(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.

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

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer shall respond to the prior 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:

(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 health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment 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.

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

(k) If a health care practitioner, hospital, or department within a hospital ~~has performed an average of 30 procedures~~ submitted at least 10 prior authorizations 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, hospital, or department within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months, or longer if the insurer allows: *Provided*, That, at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. 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 by the health insurer at any time 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 plan, it identifies substantial variances in historical utilization, or identifies or anomalies based upon the results of the health insurer'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 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 service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, ~~2024~~ 2027. 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 approved after appeal by health care providers, the name of each gold card status physician, hospital, or department within a hospital and the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

(n) If a health care practitioner, hospital, or department within a hospital believes it qualifies for gold card status, but has not yet been awarded, it may request from the West Virginia Office of the Insurance Commissioner (OIC) the underlying source data and performance metrics used to determine his or her gold card status. The OIC shall provide this information within 24 hours of the request.

(o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall implement a standardized gold carding process for all payors.

(p) The Insurance Commissioner may assess a civil penalty of up to $10,000 per violation of this section.

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, imaging, 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.

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

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication with a cost over $10,000.

(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:

(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.

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

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer shall respond to the prior 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:

(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 health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment 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 day 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 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.

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

(k) If a health care practitioner, hospital, or department within a hospital has ~~performed an average of 30 procedures~~ submitted at least 10 prior authorizations 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, hospital, or department within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months, or longer if the insurer allows: *Provided*, That, at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. If approved, this 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, at any time, 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 plan, it identifies substantial variances in historical utilization or identifies other anomalies based upon the results of the health insurer'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 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 service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, ~~2024~~ 2027. 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 approved after appeal by health care providers, the name of each gold card status physician, hospital, or department within a hospital the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

(n) If a health care practitioner, hospital, or department within a hospital believes it qualifies for gold card status, but has not yet been awarded, it may request from the West Virginia Office of the Insurance Commissioner (OIC) the underlying source data and performance metrics used to determine his or her gold card status. The OIC shall provide this information within 24 hours of the request.

(o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall implement a standardized gold carding process for all payors.

(p) The Insurance Commissioner may assess a civil penalty of up to $10,000 per violation of this section.

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, imaging, 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.

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

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication with a cost over $10,000.

(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:

(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.

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

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer shall respond to the prior 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:

(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 health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment 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 day 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 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.

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

(k) If a health care practitioner, hospital, or department within a hospital has ~~performed an average of 30 procedures~~ submitted at least 10 prior authorizations 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, hospital, or department within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months, or longer if the insurer allows: *Provided*, That, at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer is 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 practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variance in historical utilization, or other anomalies based upon the results of the health insurer'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 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 service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, ~~2024~~ 2027. 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 approved after appeal by health care

providers, the name of each gold card status physician, hospital, or department within a hospital the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

(n) If a health care practitioner, hospital, or department within a hospital believes it qualifies for gold card status, but has not yet been awarded, it may request from the West Virginia Office of the Insurance Commissioner (OIC) the underlying source data and performance metrics used to determine his or her gold card status. The OIC shall provide this information within 24 hours of the request.

(o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall implement a standardized gold carding process for all payors.

(p) The Insurance Commissioner may assess a civil penalty of up to $10,000 per violation of this section.

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:

"Episode of care" means a specific medical problem, condition, or specific illness being managed including tests, imaging, 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.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United

States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health maintenance organization about the coverage of a service or medication with a cost over $10,000.

(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:

(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 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 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.

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

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health maintenance organization shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request, except that the health maintenance organization shall respond to the prior 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:

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

(e) If the information submitted is considered incomplete, the health maintenance organization 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 day 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 the additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health maintenance organization 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 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.

(h) The health maintenance organization shall use national best practice guidelines to 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.

(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, hospital, or department within a hospital has ~~performed an average of 30 procedures~~ submitted at least 10 prior authorizations per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the health maintenance organization may not require the health care practitioner, hospital, or department

within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months or longer if the insurer allows: *Provided*, That at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. 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, at any time, by the health maintenance organization and may be rescinded if the health maintenance organization determines the health care practitioner is not performing services or procedures in conformity with the health maintenance organization's benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results 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 this subsection may be interpreted to prohibit an insurer from requiring prior authorization for an experimental treatment, non-covered benefit, or any out-of-network service or procedure. This subsection shall not apply to pharmaceutical medications or services or procedures where the benefit maximums or minimums have been required by statute or policy of the Bureau for Medical Services as it relates to the Medicaid Program.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, ~~2024~~ 2027. 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 approved after appeal by health care

providers, the name of each gold card status physician, hospital, or department within a hospital the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

(n) If a health care practitioner, hospital, or department within a hospital believes it qualifies for gold card status, but has not yet been awarded, it may request from the West Virginia Office of the Insurance Commissioner (OIC) the underlying source data and performance metrics used to determine his or her gold card status. The OIC shall provide this information within 24 hours of the request.

(o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall implement a standardized gold carding process for all payors.

(p) The Insurance Commissioner may assess a civil penalty of up to $10,000 per violation of this section.

NOTE: The purpose of this bill is to expand the definition of episode of care and the definition of prior authorization; to revise the requirements for the gold card process to include a hospital, or a department within a hospital; to extend the timeframe for which the gold care is effective; to allow the Office of the Insurance Commissioner to respond within 24 hours if a gold card provider believes he or she has been improperly denied; to implement a standard gold card process; to increase fines; and to establish a new effective date.

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