WEST VIRGINIA LEGISLATURE

2017 REGULAR SESSION

Introduced

Senate Bill 49

BY SENATOR FERNS

[Introduced February 8, 2017; referred

to the Committee on Banking and Insurance; and then to

the Committee on Health and Human Resources]

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

Be it enacted by the Legislature of West Virginia:

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

ARTICLE 45. ETHICS AND FAIRNESS IN INSURER BUSINESS PRACTICES.

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

(a) As used in this section, unless the context requires a different meaning:

"Insurer" has the same meaning ascribed thereto in section two, article one of this chapter.

"Chronic disease management drug" means any drug used to treat an insured's chronic, incurable, permanent or recurring medical condition.

"Mental health drug" means any drug prescribed to treat an insured's mental disorder, including psychological, behavioral, or emotional disorders.

"Prior authorization" means the approval process used by a carrier before certain drug benefits may be provided.

"Insurance" has the same meaning ascribed thereto in section one, article one of this chapter.

"Step therapy restrictions" means a restriction by a carrier requiring the use of additional steps, such as attempting other drug options, prior to approval of a drug benefit subject to prior authorization.

"Supplementation" means an electronic request communicated by the insurer or its intermediary to the provider for additional information, limited to items identified on the applicable prior authorization request form, necessary to approve or deny a prior authorization request.

"Universal prior authorization form" means a form made available by the commissioner for

use in prior authorization.

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

(1) Accept universal prior authorization forms;

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

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

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

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

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

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

(8) Require that, if a prior authorization request is approved by the insurer, the prior authorization approval be valid for not less than one year;

(9) Require that if the prior authorization request is denied, the insurer shall communicate the reasons for the denial electronically to the prescriber within the periods set forth in subdivisions six and seven;

(10) Require that prior authorization of a three-day supply of a prescribed drug be deemed to be approved where delay in filling the prescribed drug could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in: (A) Serious jeopardy to the mental, behavioral, emotional, or physical health of the insured; (B) danger of serious impairment of the insured's bodily functions; (C) serious dysfunction of any of the insured's bodily organs; or (D) in the case of a pregnant insured, serious jeopardy to the health of the fetus;

(11) Require prior authorization for generic drug benefits only when: (A) The prescribed drug is an opioid; or (B) when the carrier's cost of reimbursement for the generic drug benefit exceeds its cost of reimbursement for the brand name drug;

(12) Require that a tracking number be assigned by the insurer to all prior authorization requests and that the tracking number be provided electronically to the prescriber upon the insurer's receipt of the prior authorization request; and

(13) Require that the insurer's prescription drug formularies, all drug benefits subject to prior authorization by the insurer, all of the insurer's prior authorization procedures, and all prior authorization request forms accepted by the insurer be centrally located on the insurer's website and that such postings be updated by the insurer within seven days of approved changes.

(c) The provisions of this section are inapplicable where the insurer has evidence of fraud, waste, or abuse by the insured or the prescriber and the insurer has notified the prescriber that the provisions of this section are accordingly inapplicable.

(d) The commissioner has no jurisdiction to adjudicate individual controversies arising out of this section.

(e) This section applies with respect to any contract between an insurer and a participating

health care provider, or its contracting agent, pursuant to which the insurer has the right or obligation to require prior authorization for a drug benefit, that is entered into, amended, extended, or renewed on or after January 1, 2017.

(f) That on or before December 1, 2017, and annually thereafter, the West Virginia Academy of Family Physicians, the West Virginia State Medical Association, the American Academy of Pediatrics - West Virginia Chapter, the American College of Physicians - West Virginia Chapter, the West Virginia Psychiatric Association, the West Virginia Pharmacists Association and other appropriate health care provider and insurer stakeholders shall develop, and annually update, universal prior authorization forms. Such forms shall be provided to the Insurance Commissioner in both electronic and nonelectronic formats, shall be disease state specific, shall contain a check box for the provider to enter patient specific information, and shall enable the prescriber to submit a renewal request by marking the form to indicate there has been no change in the patient's condition since the last prior authorization request. The commission shall make the universal prior authorization forms available, in both electronic and nonelectronic formats, on or before January 1, 2018, and shall make revised universal prior authorization forms available annually thereafter.

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

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