WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Introduced

Senate Bill 762

BY SENATORS MARONEY, TAKUBO, LINDSAY, BALDWIN,

STOLLINGS, WOELFEL, AND RUCKER

[Introduced February 13, 2020; referred

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 article, designated §33-25H-1, §33-25H-2, §33-25H-3, and §33-25H-4, all relating to creating the Preserving Patient Stability Act of 2020; setting forth definitions; prohibiting nonmedical switching of biological products; recognizing exemptions; and providing for enforcement.

Be it enacted by the Legislature of West Virginia:

ARTICLE 25H. PRESERVING PATIENT STABILITY ACT OF 2020.

§ 33-25H-1. Definitions.

For purposes of this article:

"Biological product" means the same as the term is defined in 42 U.S.C. § 2262.

"Commissioner" means the Insurance Commissioner of West Virginia.

"Cost-sharing" means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense requirement.

"Coverage Exemption Determination" means a determination made by the third-party payer to cover a medication that would otherwise be excluded from coverage.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health insurance plan.

"Formulary" means a complete list of drugs eligible for coverage under a health insurance plan.

"Health care provider" means a physician or other health care practitioner licensed, accredited, or certified to perform specified physical, mental, or behavioral health care services consistent with his or her scope of practice under state law.

"Health insurance plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a third-party payer to provide, deliver, arrange for, pay for, or reimburse prescription drugs, health care services, and other covered health care benefits.

"Renewal period" means the term in which a covered person has been continuously enrolled in a health insurance plan after the termination date of a prior year in which the covered

person was enrolled.

"Third-party payer" means a health insurer; third-party administrator; carrier; plan sponsor; prescription drug benefit manager; nonprofit hospital service corporation; medical service corporation; prepaid limited health service organization; health maintenance organization; preferred provider organization; provider-sponsored network; state government payer, including, but not limited to, Medicaid and the Public Employees Insurance Agency; or any other party that administers a fully-insured plan and is contractually obligated to provide coverage or a health insurance plan to pay for covered health care services or prescription drug benefits rendered to covered persons.

§33-25H-2. Nonmedical Switching.

(a) For each third-party payer that has entered into a health insurance plan contract with a covered person that covers prescription drug benefits:

(1) Third-party payers shall not limit or exclude coverage of a biological product, for any covered person who is medically stable on such drug as determined by the prescribing provider, if:

(A) The biological product previously had been approved for coverage by the third-party payer for the covered person;

(B)The covered person's prescribing provider continues to prescribe the biological product for the medical condition; and

(C) The covered person continues to be an enrollee of the health insurance plan.

(b) Coverage of covered person's medication, as described in subsection (a), shall continue through the last day of the covered person's eligibility under the health insurance plan, inclusive of any renewal period.

(c) Prohibited limitations and exclusions referred to in subsection (a) include, but are not limited to:

(1) Limiting or reducing the maximum coverage of prescription drug benefits;

(2) Increasing out-of-pocket costs for a covered drug;

(3) Moving a prescription drug to a more restrictive tier, if the third-party payer uses a formulary with tiers; or

(4) Removing a prescription drug from a formulary.

(d) This article does not preclude the prescribing provider from prescribing another biological product covered by the third-party payer that the prescribing provider deems medically necessary for the covered person.

(e) This article does not prohibit a third-party payer from:

(1) Adding a biological product to its formulary; or

(2) Removing a biological product from its formulary if its manufacturer has removed the biological product for sale in the United States.

§33-25H-3. Exemption Process.

(a) To ensure continuity of care, the third-party payer shall provide the covered person and prescribing practitioner with access to a clear, readily accessible, and convenient process to request a Coverage Exemption Determination.

(b) A Coverage Exemption Determination shall expeditiously grant the exemption determination request if the third-party payer discontinues the covered person's previous health care plan during open enrollment, the covered person enrolls in a comparable plan offered by the same third-party payer, and the following conditions are met:

(1) The covered person is medically stable on a biological product as determined by the prescribing provider; and

(2) The prescribing provider continues to prescribe the biological product to the covered person for the medical condition; and

(3) In comparison to the Discontinued Health Insurance Plan, the new health insurance plan:

(A) Limits or reduces the maximum coverage of prescription drug benefits;

(B) Increases out-of-pocket costs for the drug;

(C) Moves the drug to a more restrictive tier, if the third-party payer uses a formulary with tiers; or

(D) Excludes the drug from a formulary.

(c) Upon the granting of a Coverage Exemption Determination request, the third-party payer shall authorize coverage no more restrictive than that offered in the Discontinued Health Insurance Plan for the biological product prescribed by the covered person's prescribing provider.

(d) The third-party payer shall respond to a Coverage Exemption Determination request or an appeal within 72 hours of receipt. In cases where exigent circumstances exist, a third-party payer shall respond within 24 hours of receipt. Should a response by a third-party payer not be received within this time allotted, the appeal shall be deemed granted.

§33-25H-4. Enforcement.

If the commissioner suspects that a third-party payer has violated any provision of this article, the commissioner may take any enforcement action pursuant to the provisions of §33-2-1 *et* seq. of this code.

Note: The purpose of this bill is to ensure that covered persons who are stable on their biological product prescription drug regimens, as determined by the prescribing provider, have continuous care and that third-party payers cannot make restrictive changes to their formularies after a plan year has begun or has been renewed, resulting in increased cost-sharing or loss of access to a medication—a practice referred to as "nonmedical switching."

Strike-through indicates language that would be stricken from a heading or present law, and underscoring indicates new language that would be added.