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SENATE BILL NO. 1262

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on February 2, 2015)

(Patron Prior to Substitute—Senator Newman)

A BILL to amend the Code of Virginia by adding a section numbered 38.2-3407.15:2, relating to health insurance; carrier business practices; prior authorization provisions.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.2-3407.15:2 as follows:

§ 38.2-3407.15:2. Carrier contracts; required provisions regarding prior authorization.

A. As used in this section, unless the context requires a different meaning:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

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

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Supplementation" means a request communicated by the carrier to the prescriber or his designee, for additional information, limited to items specifically requested on the applicable prior authorization request, necessary to approve or deny a prior authorization request.

B. Any provider contract between a carrier and a participating health care provider, or its contracting agent, shall contain specific provisions that:

1. Require the carrier to, in a method of its choosing, accept telephonic, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards;

2. Require that the carrier communicate to the prescriber or his designee, within 24 hours of receipt of an urgent prior authorization request, if received telephonically or as otherwise directed to be received by the carrier, from the prescriber or his designee, that the request is approved, denied, or requires supplementation;

3. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of receipt of a fully completed prior authorization request, that the request is approved, denied, or requires supplementation;

4. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of receipt of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied;

5. Require that if the prior authorization request is denied, the carrier shall communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by subdivision 3 or 4, as applicable, the reasons for the denial;

6. Require that prior authorization approved by another carrier be honored at least for the initial 30 days of a member's prescription drug benefit coverage, subject to the provisions of the new carrier's evidence of coverage, upon the carrier's receipt from the prescriber or his designee, of a record demonstrating the previous carrier's prior authorization approval;

7. Require that a tracking system be used by the carrier for all prior authorization requests and that the identification information be provided electronically, telephonically, or by facsimile to the prescriber or his designee, upon the carrier's response to the prior authorization request;

8. Require that the carrier's prescription drug formularies, all drug benefits subject to prior authorization by the carrier, all of the carrier's prior authorization procedures, and all prior authorization request forms accepted by the carrier be made available through one central location on the carrier's website and that such information be updated by the carrier within seven days of approved changes; and

9. Require that calculation of the required response time set forth in subdivisions 2, 3, and 4 shall accrue from the time of the submission of the request.

C. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

D. This section shall apply with respect to any contract between a carrier and a participating health care provider, or its contracting agent, that is entered into, amended, extended, or renewed on or after January 1, 2016.

E. Notwithstanding any law to the contrary, the provisions of this section shall not apply to:

1. Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the

Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE);

2. The state employee health insurance plan established pursuant to § 2.2-2818;

3. Accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages;

4. Any dental services plan or optometric services plan as defined in § 38.2-4501; or

5. Any health maintenance organization that (i) contracts with one multispecialty group of physicians who are employed by and are shareholders of the multispecialty group, which multispecialty group of physicians may also contract with health care providers in the community; (ii) provides and arranges for the provision of physician services by such multispecialty group physicians or by such contracted health care providers in the community; and (iii) receives and processes at least 85 percent of prescription drug prior authorization requests in a manner that is interoperable with e-prescribing systems, electronic health records, and health information exchange platforms.

2. That the Virginia Association of Health Plans, the Medical Society of Virginia, and the Virginia Academy of Family Physicians shall convene a workgroup, including appropriate provider, carrier, and pharmacy benefit manager stakeholders, to identify common evidence-based parameters for carrier approval of the 10 most frequently prescribed chronic disease management prescription drugs subject to prior authorization by a majority of carriers, the 10 most frequently prescribed mental health prescription drugs subject to prior authorization by a majority of carriers, and generic prescription drugs subject to prior authorization by a majority of carriers. The workgroup shall report its findings to the Health Insurance Reform Commission and the Chairmen of the House and Senate Commerce and Labor Committees by July 1, 2016.