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HOUSE BILL NO. 1942

Offered January 14, 2015
Prefiled January 13, 2015

A BILL to amend and reenact § 38.2-4509 of the Code of Virginia and 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.

Patrons—Habeeb, Austin, Bell, Richard P., Campbell, Garrett, Greason, Helsel, Leftwich, Lopez, O'Bannon, Peace, Pillion, Pogge, Ransone, Rust, Stolle, Ware, Wilt and Yost

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4509 of the Code of Virginia is amended and reenacted and 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.

"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.

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

"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 carrier 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 Commission for use in prior authorization.

B. Any provider contract between a carrier and a participating health care provider, or its contracting agent, pursuant to which the carrier 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 (i) is not medically stable on the prescribed drug or (ii) has not completed prior step therapy, if required, for the prescribed drug;

5. Require that prior authorization approved by another carrier be honored for the initial 90 days of an insured's prescription drug benefit coverage upon the carrier's receipt from the prescriber of a record demonstrating the previous carrier's prior authorization approval;

6. Require that prior authorization requests be deemed to be approved unless the carrier has communicated electronically to the prescriber within 48 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 carrier has communicated electronically to the prescriber within 24 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 carrier, the prior authorization approval be valid for not less than one year;

9. Require that if the prior authorization request is denied, the carrier shall communicate the reasons for the denial electronically to the prescriber within the periods set forth in subdivisions 6 and 7;

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 (i) serious jeopardy to the mental, behavioral, emotional, or physical health of the insured; (ii) danger of serious impairment of the insured's bodily functions; (iii) serious dysfunction of any of the insured's bodily organs; or (iv) 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 (i) the prescribed drug is an opioid or (ii) 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 carrier to all prior authorization requests and that the tracking number be provided electronically to the prescriber upon the carrier's receipt of the prior authorization request; and

13. 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 centrally located on the carrier's website and that such postings be updated by the carrier within seven days of approved changes.

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

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

E. This section shall apply with respect to any contract between a carrier and a participating health care provider, or its contracting agent, pursuant to which the carrier 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, 2016.

F. Notwithstanding any law to the contrary, the provisions of this section shall not apply to (i) 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); (ii) the State Employee Health Insurance Program; or (iii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, Articles 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 6 (§ 38.2-1335 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.1, 38.2-3407.4, 38.2-3407.10, 38.2-3407.13, 38.2-3407.14, 38.2-3407.15, *38.2-3407.15:2,* 38.2-3407.17, 38.2-3415, 38.2-3541, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall apply to the operation of a plan.

B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

C. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not apply to either an optometric or dental services plan.

D. The provisions of § 38.2-3407.1 shall apply to claim payments made on or after January 1, 2014. No optometric or dental services plan shall be required to pay interest computed under § 38.2-3407.1 if the total interest is less than $5.

2. That on or before December 1, 2015, and annually thereafter, the Virginia Academy of Family Physicians, the Medical Society of Virginia, the American Academy of Pediatrics - Virginia Chapter, the American College of Physicians - Virginia Chapter, the Psychiatric Society of Virginia, the Virginia Pharmacists Association, the Virginia Association of Health Plans, and other appropriate health care provider and carrier stakeholders shall develop, and annually update, universal prior authorization forms. Such forms shall be provided to the State Corporation Commission (Commission) 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, 2016, and shall make revised universal prior authorization forms available annually thereafter.