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SENATE BILL NO. 731

Offered January 10, 2018

Prefiled January 10, 2018

A BILL to amend and reenact § 38.2-3407.15:2 of the Code of Virginia, relating to health insurance; carrier business practices; prior authorization provisions.

Patron—Dunnavant

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3407.15:2 of the Code of Virginia is amended and reenacted 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.

"Covered individual" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health plan.

"Health plan" 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 *or surgical procedures* 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 *involving drug benefits* 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~~ *participating health care provider* or his designee within 24 hours of submission of an urgent prior authorization request to the carrier, if submitted telephonically or in an alternate method directed by the carrier, that the request is approved, denied, or requires supplementation;

3. Require that the carrier communicate electronically, telephonically, or by facsimile to the ~~prescriber~~ *participating health care provider* or his designee, within two business days of submission 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~~ *participating health care provider* or his designee, within two business days of submission of a properly completed supplementation from the ~~prescriber~~ *participating health care provider* 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~~ *participating health care provider* or his designee, within the timeframes established by subdivision 3 or 4, as applicable, the reasons for the denial;

6. Require that prior authorization *involving drug benefits* 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 *involving drug benefits* 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; ~~and~~

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*;*

9. If a carrier approves a request for prior authorization submitted by a participating health care

provider or its contracting agent, the carrier shall not subsequently withdraw or retract the authorization or decline or refuse to pay a claim submitted for such drug benefit or surgical procedure by the participating health care provider or its contracting agent;

10. If a health plan or provider contract provides that prior authorization is not required for a specific drug benefit or surgical procedure, the carrier shall not refuse to pay a claim submitted for such drug benefit or surgical procedure by a participating health care provider or its contracting agent;

11. Notwithstanding the provisions of subdivision 1, a health plan shall accept and respond to a request for prior authorization involving a drug benefit delivered to the health plan by a covered individual's prescribing participating health care provider through an electronic transmission that complies with the technical standards developed by the National Council for Prescription Drug Programs for electronic prior authorization transactions (NCPDPSCRIPT), unless the prescribing participating health care provider lacks:

a. Broadband Internet access;

b. An electronic medical record system; or

c. A sufficient number of covered individuals as patients, as determined by the Commission, to warrant the financial expense that compliance with this subdivision would require, in which event the request for prior authorization may be submitted by mail, facsimile, or other paper means of transmission;

12. Prior authorization shall not be required for a drug benefit if prior authorization has been approved for such drug benefit in 90 percent or more of the prior authorization requests submitted to the carrier by the prescribing participating health care provider in the preceding 12-month period; and

13. Prior authorization shall not be required for a generic medication.

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, *except that the provisions of subdivisions B 9 through 13 and the application of this section to surgical procedures 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, 2019.*

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.