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Sixty-ninth General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 13-0886.01 Christy Chase x2008 **SENATE BILL 13-277**

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A BILL FOR AN ACT

CONCERNING THE DEVELOPMENT OF A PRIOR AUTHORIZATION PROCESS TO BE USED IN OBTAINING PRIOR APPROVAL FROM CARRIERS FOR COVERAGE OF DRUG BENEFITS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://www.leg.state.co.us/billsummaries.)

The bill requires the commissioner of insurance (commissioner) to develop, by July 31, 2014, and prescribing providers, carriers, and, if applicable, pharmacy benefit management firms (PBMs), to use, by January 1, 2015, a uniform prior authorization process for purposes of

submitting and receiving requests for prior coverage approval of a drug benefit.

The commissioner is directed to adopt rules to establish the prior authorization process, which is to include specified components aimed at creating uniformity and reducing administrative burdens on prescribing providers, carriers, and PBMs, as well as making the criteria used for deciding prior authorization requests transparent and establishing a procedure for waiving the process under extenuating circumstances.

To assist in developing the process, the commissioner is to appoint a work group of various stakeholders to make recommendations on specified aspects of the process that the commissioner is to consider, including national standards for electronic prior authorization.

Once the prior authorization process is established, the request is deemed granted if a carrier or PBM fails to use or accept the prior authorization process, fails to notify the prescribing provider within a specified period that the request is approved or denied or that additional information is required to process the request, or fails to notify the prescribing provider within a specified period after receipt of the required additional information that the request is approved or denied. An approved prior authorization is valid for at least 180 days after the date of approval.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly hereby finds that:

(a) Carriers and pharmacy benefit management firms routinely require health care providers to request prior authorization when prescribing medications or treatments not routinely covered by health plan formularies;

(b) Each carrier and pharmacy benefit management firm has its own prior authorization process, and the multiplicity of prior authorization processes imposes a significant administrative burden on health care providers, resulting in delayed patient access to medication and increased administrative costs; and

(c) A standardized prior authorization process that any health care

provider can use, regardless of the carrier, pharmacy benefit management firm, or health plan that covers that provider's patient, will simplify the administrative process and improve patient care by allowing health care providers to devote less time to administrative duties and more time to patient care.

SECTION 2. In Colorado Revised Statutes, **add** 10-16-124.5 as follows:

10-16-124.5. Prior authorization form - drug benefits - rules of commissioner - definition. (1) (a) NOTWITHSTANDING ANY OTHER PROVISION OF LAW BUT SUBJECT TO PARAGRAPH (b) OF THIS SUBSECTION (1), ON AND AFTER JANUARY 1, 2015, A CARRIER OR, IF A CARRIER CONTRACTS WITH A PHARMACY BENEFIT MANAGEMENT FIRM TO PERFORM PRIOR AUTHORIZATION SERVICES FOR DRUG BENEFITS, THE PHARMACY BENEFIT MANAGEMENT FIRM, SHALL UTILIZE THE PRIOR AUTHORIZATION PROCESS DEVELOPED PURSUANT TO SUBSECTION (3) OF THIS SECTION WHEN REQUIRING PRIOR AUTHORIZATION FOR DRUG BENEFITS.

(b) THIS SECTION DOES NOT APPLY TO A NONPROFIT HEALTH MAINTENANCE ORGANIZATION WITH RESPECT TO MANAGED CARE PLANS THAT PROVIDE A MAJORITY OF COVERED PROFESSIONAL SERVICES THROUGH A SINGLE CONTRACTED MEDICAL GROUP.

(2) (a) EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (2), A PRIOR AUTHORIZATION REQUEST IS DEEMED GRANTED IF A CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM FAILS TO:

(I) UTILIZE THE PRIOR AUTHORIZATION PROCESS DEVELOPED PURSUANT TO SUBSECTION (3) OF THIS SECTION;

(II) FOR PRIOR AUTHORIZATION REQUESTS SUBMITTED ELECTRONICALLY:

(A) NOTIFY THE PRESCRIBING PROVIDER, WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED, DENIED, OR INCOMPLETE, AND IF INCOMPLETE, INDICATE THE SPECIFIC ADDITIONAL INFORMATION, CONSISTENT WITH CRITERIA POSTED PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (a) OF SUBSECTION (3) OF THIS SECTION, THAT IS REQUIRED TO PROCESS THE REQUEST; OR

(B) NOTIFY THE PRESCRIBING PROVIDER, WITHIN TWO BUSINESS DAYS AFTER RECEIVING THE ADDITIONAL INFORMATION REQUIRED BY THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM PURSUANT TO SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (II), THAT THE REQUEST IS APPROVED OR DENIED;

(III) FOR NONURGENT PRIOR AUTHORIZATION REQUESTS SUBMITTED ORALLY OR BY FACSIMILE OR ELECTRONIC MAIL, NOTIFY THE PRESCRIBING PROVIDER, WITHIN THREE BUSINESS DAYS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED OR DENIED; AND

(IV) FOR URGENT PRIOR AUTHORIZATION REQUESTS SUBMITTED ORALLY OR BY FACSIMILE OR ELECTRONIC MAIL, NOTIFY THE PRESCRIBING PROVIDER, WITHIN ONE DAY AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED OR DENIED.

(b) IF A CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM NOTIFIES THE PRESCRIBING PROVIDER PURSUANT TO SUB-SUBPARAGRAPH (A) OF SUBPARAGRAPH (II) OF PARAGRAPH (a) OF THIS SUBSECTION (2) THAT A PRIOR AUTHORIZATION REQUEST IS INCOMPLETE AND THAT ADDITIONAL INFORMATION IS REQUIRED, THE PRESCRIBING PROVIDER SHALL SUBMIT THE ADDITIONAL INFORMATION WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE NOTICE FROM THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM. IF THE PRESCRIBING PROVIDER FAILS TO

SUBMIT THE REQUIRED ADDITIONAL INFORMATION WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE NOTICE, THE REQUEST IS NOT DEEMED GRANTED PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (2). AFTER RECEIPT OF THE REQUIRED ADDITIONAL INFORMATION, THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM SHALL RESPOND TO THE PRIOR AUTHORIZATION REQUEST IN ACCORDANCE WITH SUB-SUBPARAGRAPH (B) OF SUBPARAGRAPH (II) OF PARAGRAPH (a) OF THIS SUBSECTION (2).

(3) (a) ON OR BEFORE JULY 31, 2014, THE COMMISSIONER SHALL DEVELOP, BY RULE, A UNIFORM PRIOR AUTHORIZATION PROCESS THAT:

(I) IS MADE AVAILABLE ELECTRONICALLY BY THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM BUT THAT DOES NOT REQUIRE THE PRESCRIBING PROVIDER TO SUBMIT A PRIOR AUTHORIZATION REQUEST ELECTRONICALLY;

(II) REQUIRES EACH CARRIER AND PHARMACY BENEFIT MANAGEMENT FIRM TO MAKE THE FOLLOWING AVAILABLE AND ACCESSIBLE IN A CENTRALIZED LOCATION ON ITS WEB SITE:

(A) ITS PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS, INCLUDING A LIST OF DRUGS THAT REQUIRE PRIOR AUTHORIZATION;

(B) WRITTEN CLINICAL CRITERIA THAT ARE EASILY UNDERSTANDABLE TO THE PRESCRIBING PROVIDER AND THAT INCLUDE THE CLINICAL CRITERIA FOR REAUTHORIZATION OF A PREVIOUSLY APPROVED DRUG AFTER THE PRIOR AUTHORIZATION PERIOD HAS EXPIRED; AND

(C) THE STANDARD FORM FOR SUBMITTING REQUESTS;

(III) ENSURES THAT CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS USE EVIDENCE-BASED GUIDELINES, WHEN POSSIBLE, WHEN MAKING PRIOR AUTHORIZATION DETERMINATIONS;

(IV) PERMITS, BUT DOES NOT REQUIRE, A PRESCRIBING PROVIDER

TO SUBMIT A REQUEST FOR A PRIOR AUTHORIZATION FOR DRUG BENEFITS ELECTRONICALLY TO THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM;

(V) REQUIRES CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS, WHEN NOTIFYING THE PRESCRIBING PROVIDER OF ITS DECISION TO APPROVE A PRIOR AUTHORIZATION REQUEST, TO INCLUDE IN THE NOTICE A UNIQUE PRIOR AUTHORIZATION NUMBER ATTRIBUTABLE TO THE PARTICULAR REQUEST, SPECIFICATION OF THE PARTICULAR DRUG BENEFIT APPROVED, THE NEXT DATE FOR REVIEW OF THE APPROVED DRUG BENEFIT, AND A LINK TO THE CURRENT CRITERIA THAT THE PRESCRIBING PROVIDER WILL NEED TO SUBMIT FOR REAPPROVAL OF THE PRIOR AUTHORIZATION; AND

(VI) REQUIRES CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS, WHEN NOTIFYING A PRESCRIBING PROVIDER OF ITS DECISION TO DENY A PRIOR AUTHORIZATION REQUEST, TO INCLUDE A NOTICE THAT THE COVERED PERSON HAS A RIGHT TO APPEAL THE ADVERSE DETERMINATION PURSUANT TO SECTIONS 10-16-113 AND 10-16-113.5.

(b) IN DEVELOPING THE UNIFORM PRIOR AUTHORIZATION PROCESS, THE COMMISSIONER SHALL TAKE INTO CONSIDERATION THE RECOMMENDATIONS, IF ANY, OF THE WORK GROUP ESTABLISHED PURSUANT TO SUBSECTION (4) OF THIS SECTION AND THE FOLLOWING:

(I) NATIONAL STANDARDS PERTAINING TO ELECTRONIC PRIOR AUTHORIZATION, INCLUDING, BUT NOT LIMITED TO, STANDARDS REFERENCED IN FEDERAL LAW;

(II) WHETHER THE PRIOR AUTHORIZATION PROCESS SHOULD

REQUIRE CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS, WHEN REVIEWING A PRIOR AUTHORIZATION REQUEST, TO USE CLEARLY ACCESSIBLE, CONSISTENTLY APPLIED, AND WRITTEN CLINICAL CRITERIA BASED ON MEDICAL NECESSITY OR THE APPROPRIATENESS OF THE DRUG BENEFIT FOR THE COVERED PERSON;

(III) WHETHER THE PRIOR AUTHORIZATION PROCESS SHOULD REQUIRE CARRIERS TO TAKE INTO ACCOUNT, IN DETERMINING CRITERIA FOR PRIOR AUTHORIZATIONS, THE COLORADO PART B MEDICARE CONTRACTOR LOCAL COVERAGE DETERMINATIONS, THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES NATIONAL COVERAGE DETERMINATIONS, AND SPECIALTY SOCIETY GUIDELINES, SUCH AS THOSE OF THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY; AND

(IV) WHETHER CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS COULD USE A RULES ENGINE WITH CRITERIA-DRIVEN QUESTIONS THAT LEAD TO AN IMMEDIATE DETERMINATION OF A PRIOR AUTHORIZATION REQUEST OR REQUEST FOR SUBMITTAL OF SPECIFIC ADDITIONAL INFORMATION NEEDED TO MAKE THE DETERMINATION.

(c) IN ADDITION TO THE PRIOR AUTHORIZATION PROCESS, THE COMMISSIONER SHALL DEVELOP, BY RULE, A STANDARDIZED PRIOR AUTHORIZATION FORM, NOT TO EXCEED TWO PAGES IN LENGTH, FOR USE IN SUBMITTING ELECTRONIC AND NONELECTRONIC PRIOR AUTHORIZATION REQUESTS. IN DEVELOPING THE FORM, THE COMMISSIONER SHALL TAKE INTO CONSIDERATION EXISTING FORMS, INCLUDING EXISTING PRIOR AUTHORIZATION FORMS ESTABLISHED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES OR THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

(4) (a) WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF THIS

SECTION, THE COMMISSIONER SHALL ESTABLISH A WORK GROUP COMPRISED OF REPRESENTATIVES OF:

(I) THE DIVISION OF INSURANCE;

(II) LOCAL AND NATIONAL CARRIERS;

(III) CAPTIVE AND NONCAPTIVE PHARMACY BENEFIT MANAGEMENT FIRMS;

(IV) PROVIDERS, INCLUDING HOSPITALS, PHYSICIANS, ADVANCED PRACTICE NURSES WITH PRESCRIPTIVE AUTHORITY, AND PHARMACISTS;

(V) DRUG MANUFACTURERS;

(VI) MEDICAL PRACTICE MANAGERS;

(VII) CONSUMERS; AND

(VIII) OTHER STAKEHOLDERS DEEMED APPROPRIATE BY THE COMMISSIONER.

(b) THE WORK GROUP SHALL ASSIST THE COMMISSIONER IN DEVELOPING THE PRIOR AUTHORIZATION PROCESS AND SHALL MAKE RECOMMENDATIONS TO THE COMMISSIONER ON THE ITEMS SET FORTH IN PARAGRAPH (b) OF SUBSECTION (3) OF THIS SECTION. THE WORK GROUP SHALL REPORT ITS RECOMMENDATIONS TO THE COMMISSIONER NO LATER THAN SIX MONTHS AFTER THE COMMISSIONER APPOINTS THE WORK GROUP MEMBERS. REGARDLESS OF WHETHER THE WORK GROUP SUBMITS RECOMMENDATIONS TO THE COMMISSIONER, THE COMMISSIONER SHALL NOT DELAY OR EXTEND THE DEADLINE FOR THE ADOPTION OF RULES CREATING THE PRIOR AUTHORIZATION PROCESS AS SPECIFIED IN PARAGRAPH (a) OF SUBSECTION (3) OF THIS SECTION.

(5) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, ON AND AFTER JANUARY 1, 2015, EVERY PRESCRIBING PROVIDER SHALL USE THE PRIOR AUTHORIZATION PROCESS DEVELOPED PURSUANT TO SUBSECTION

(3) OF THIS SECTION TO REQUEST PRIOR AUTHORIZATION FOR COVERAGE OF DRUG BENEFITS, AND EVERY CARRIER AND PHARMACY BENEFIT MANAGEMENT FIRM SHALL USE THAT PROCESS FOR PRIOR AUTHORIZATION FOR DRUG BENEFITS.

(6) UPON APPROVAL BY THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM, A PRIOR AUTHORIZATION IS VALID FOR AT LEAST ONE HUNDRED EIGHTY DAYS AFTER THE DATE OF APPROVAL. IF, AS A RESULT OF A CHANGE TO THE CARRIER'S FORMULARY, THE DRUG FOR WHICH THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM HAS PROVIDED PRIOR AUTHORIZATION IS REMOVED FROM THE FORMULARY OR MOVED TO A LESS PREFERRED TIER STATUS, THE CHANGE IN THE STATUS OF THE PREVIOUSLY APPROVED DRUG DOES NOT AFFECT A COVERED PERSON WHO RECEIVED PRIOR AUTHORIZATION BEFORE THE EFFECTIVE DATE OF THE CHANGE FOR THE REMAINDER OF THE COVERED PERSON'S PLAN YEAR.

(7) FOR PURPOSES OF THIS SECTION, A PRIOR AUTHORIZATION REQUEST IS SUBMITTED "ELECTRONICALLY" IF THE PRESCRIBING PROVIDER SUBMITS THE REQUEST TO THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM THROUGH A SECURE, WEB-BASED INTERNET PORTAL. A PRIOR AUTHORIZATION REQUEST SUBMITTED BY ELECTRONIC MAIL IS NOT SUBMITTED "ELECTRONICALLY".

(8) AS USED IN THIS SECTION:

(a) "PRESCRIBING PROVIDER" MEANS A PROVIDER WHO IS:

(I) AUTHORIZED BY LAW TO PRESCRIBE ANY DRUG OR DEVICE TO TREAT A MEDICAL CONDITION OF A COVERED PERSON; AND

(II) ACTING WITHIN THE SCOPE OF THAT AUTHORITY.

(b) "URGENT PRIOR AUTHORIZATION REQUEST" MEANS A REQUEST FOR PRIOR AUTHORIZATION OF A DRUG BENEFIT THAT, BASED ON THE

REASONABLE OPINION OF THE PRESCRIBING PROVIDER WITH KNOWLEDGE OF THE COVERED PERSON'S MEDICAL CONDITION, IF DETERMINED IN THE TIME ALLOWED FOR NONURGENT PRIOR AUTHORIZATION REQUESTS, COULD:

(I) SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR THE ABILITY OF THE COVERED PERSON TO REGAIN MAXIMUM FUNCTION; OR

(II) SUBJECT THE COVERED PERSON TO SEVERE PAIN THAT CANNOT BE ADEQUATELY MANAGED WITHOUT THE DRUG BENEFIT THAT IS THE SUBJECT OF THE PRIOR AUTHORIZATION REQUEST.

SECTION 3. No appropriation. The general assembly has determined that this act can be implemented within existing appropriations, and therefore no separate appropriation of state moneys is necessary to carry out the purposes of this act.

SECTION 4. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.