

**First Regular Session
Sixty-ninth General Assembly
STATE OF COLORADO**

REREVISED

*This Version Includes All Amendments
Adopted in the Second House*

LLS NO. 13-0886.01 Christy Chase x2008

SENATE BILL 13-277

SENATE SPONSORSHIP

Aguilar, Morse

HOUSE SPONSORSHIP

Ginal, Duran, Fields, Garcia, Gerou, Hamner, Hullinghorst, Joshi, Melton, Moreno, Peniston, Pettersen, Primavera, Rosenthal, Ryden, Salazar, Schafer, Singer, Williams

Senate Committees

Health & Human Services

House Committees

Health, Insurance & Environment
Appropriations

A BILL FOR AN ACT

101 **CONCERNING THE DEVELOPMENT OF A PRIOR AUTHORIZATION**
102 **PROCESS TO BE USED IN OBTAINING PRIOR APPROVAL FROM**
103 **CARRIERS FOR COVERAGE OF DRUG BENEFITS, AND, IN**
104 **CONNECTION THEREWITH, MAKING AN APPROPRIATION.**

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

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

HOUSE
3rd Reading Unamended
May 6, 2013

HOUSE
Amended 2nd Reading
May 3, 2013

SENATE
Amended 3rd Reading
April 30, 2013

SENATE
Amended 2nd Reading
April 29, 2013

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.

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

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

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

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

1 (c) A standardized prior authorization process that any health care
2 provider can use, regardless of the carrier, pharmacy benefit management
3 firm, or health plan that covers that provider's patient, will simplify the
4 administrative process and improve patient care by allowing health care
5 providers to devote less time to administrative duties and more time to
6 patient care.

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

9 **10-16-124.5. Prior authorization form - drug benefits - rules**
10 **of commissioner - definition.** (1) (a) NOTWITHSTANDING ANY OTHER
11 PROVISION OF LAW BUT SUBJECT TO PARAGRAPH (b) OF THIS SUBSECTION
12 (1), ON AND AFTER JANUARY 1, 2015, A CARRIER OR, IF A CARRIER
13 CONTRACTS WITH A PHARMACY BENEFIT MANAGEMENT FIRM TO PERFORM
14 PRIOR AUTHORIZATION SERVICES FOR DRUG BENEFITS, THE PHARMACY
15 BENEFIT MANAGEMENT FIRM, SHALL UTILIZE THE PRIOR AUTHORIZATION
16 PROCESS DEVELOPED PURSUANT TO SUBSECTION (3) OF THIS SECTION
17 WHEN REQUIRING PRIOR AUTHORIZATION FOR DRUG BENEFITS.

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

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

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

27 (II) FOR PRIOR AUTHORIZATION REQUESTS SUBMITTED

1 ELECTRONICALLY:

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

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

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

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

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

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

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

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

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

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

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

24 (C) THE STANDARD FORM FOR SUBMITTING REQUESTS;

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

1 (IV) PERMITS, BUT DOES NOT REQUIRE, A PRESCRIBING PROVIDER
2 TO SUBMIT A REQUEST FOR A PRIOR AUTHORIZATION FOR DRUG BENEFITS
3 ELECTRONICALLY TO THE CARRIER OR PHARMACY BENEFIT MANAGEMENT
4 FIRM;

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

13 AND

14 ==

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

20 ==

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

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

1 (II) WHETHER THE PRIOR AUTHORIZATION PROCESS SHOULD
2 REQUIRE CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS, WHEN
3 REVIEWING A PRIOR AUTHORIZATION REQUEST, TO USE CLEARLY
4 ACCESSIBLE, CONSISTENTLY APPLIED, AND WRITTEN CLINICAL CRITERIA
5 BASED ON MEDICAL NECESSITY OR THE APPROPRIATENESS OF THE DRUG
6 BENEFIT FOR THE COVERED PERSON;

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

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

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

1 (4) (a) WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF THIS
2 SECTION, THE COMMISSIONER SHALL ESTABLISH A WORK GROUP
3 COMPRISED OF REPRESENTATIVES OF:

4 (I) THE DEPARTMENT OF REGULATORY AGENCIES;

5 (II) LOCAL AND NATIONAL CARRIERS;

6 (III) CAPTIVE AND NONCAPTIVE PHARMACY BENEFIT
7 MANAGEMENT FIRMS;

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

10 (V) DRUG MANUFACTURERS;

11 (VI) MEDICAL PRACTICE MANAGERS;

12 (VII) CONSUMERS; AND

13 (VIII) OTHER STAKEHOLDERS DEEMED APPROPRIATE BY THE
14 COMMISSIONER.

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

26 (5) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, ON AND
27 AFTER JANUARY 1, 2015, EVERY PRESCRIBING PROVIDER SHALL USE THE

1 PRIOR AUTHORIZATION PROCESS DEVELOPED PURSUANT TO SUBSECTION
2 (3) OF THIS SECTION TO REQUEST PRIOR AUTHORIZATION FOR COVERAGE
3 OF DRUG BENEFITS, AND EVERY CARRIER AND PHARMACY BENEFIT
4 MANAGEMENT FIRM SHALL USE THAT PROCESS FOR PRIOR AUTHORIZATION
5 FOR DRUG BENEFITS.

6 (6) UPON APPROVAL BY THE CARRIER OR PHARMACY BENEFIT
7 MANAGEMENT FIRM, A PRIOR AUTHORIZATION IS VALID FOR AT LEAST ONE
8 HUNDRED EIGHTY DAYS AFTER THE DATE OF APPROVAL. IF, AS A RESULT
9 OF A CHANGE TO THE CARRIER'S FORMULARY, THE DRUG FOR WHICH THE
10 CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM HAS PROVIDED PRIOR
11 AUTHORIZATION IS REMOVED FROM THE FORMULARY OR MOVED TO A LESS
12 PREFERRED TIER STATUS, THE CHANGE IN THE STATUS OF THE PREVIOUSLY
13 APPROVED DRUG DOES NOT AFFECT A COVERED PERSON WHO RECEIVED
14 PRIOR AUTHORIZATION BEFORE THE EFFECTIVE DATE OF THE CHANGE FOR
15 THE REMAINDER OF THE COVERED PERSON'S PLAN YEAR. NOTHING IN THIS
16 SUBSECTION (6) LIMITS THAT ABILITY OF A CARRIER OR PHARMACY
17 BENEFIT MANAGEMENT FIRM, IN ACCORDANCE WITH THE TERMS OF THE
18 HEALTH BENEFIT PLAN, TO SUBSTITUTE A GENERIC DRUG, WITH THE
19 PRESCRIBING PROVIDER'S APPROVAL AND PATIENT'S CONSENT, FOR A
20 PREVIOUSLY APPROVED BRAND-NAME DRUG.

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

27 (8) AS USED IN THIS SECTION:

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

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

4 (II) ACTING WITHIN THE SCOPE OF THAT AUTHORITY.

5 (b) "URGENT PRIOR AUTHORIZATION REQUEST" MEANS A REQUEST
6 FOR PRIOR AUTHORIZATION OF A DRUG BENEFIT THAT, BASED ON THE
7 REASONABLE OPINION OF THE PRESCRIBING PROVIDER WITH KNOWLEDGE
8 OF THE COVERED PERSON'S MEDICAL CONDITION, IF DETERMINED IN THE
9 TIME ALLOWED FOR NONURGENT PRIOR AUTHORIZATION REQUESTS,
10 COULD:

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

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

17 **SECTION 3. Appropriation.** In addition to any other
18 appropriation, there is hereby appropriated, out of any moneys in the
19 division of insurance cash fund created in section 10-1-103 (3), Colorado
20 Revised Statutes, not otherwise appropriated, to the department of
21 regulatory agencies, for the fiscal year beginning July 1, 2013, the sum of
22 \$8,756 and 0.1 FTE, or so much thereof as may be necessary, for
23 allocation to the division of insurance for personal services related to the
24 implementation of this act.

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