COMMONWEALTH OF VIRGINIA
Department of Health Professions
Perimeter Center, 9960 Mayland Drive, Second Floor **(804) 367-4648 (Tel)**
Henrico, Virginia 23233 **(804) 527-4434(Fax)**

Tentative Agenda of Pharmacy Benefit Manager Workgroup

November 13, 2015

9:00AM

TOPIC	PAGES
Call to Order of Meeting: David E. Brown, D.C., DHP Director	
• Revised List of Workgroup Members	1-2
Approval of Agenda	
Approval of Minutes	3-35
Call for Public Comment	
Discussion Topics:	
• Oversight of PBMs by VDH OLC with potential ability to:	
o license PBMs;	
o describe in regulation information which may be collected and/or prohibited from being collected by a PBM during the credentialing process of providers/pharmacies;	
o define "specialty drug" to describe the criteria to be used in determining drug eligibility;	
o receive complaints against PBMs and take enforcement action when warranted	
• Self-insured entities and ERISA considerations	
• Utilization of electronic prior authorization process	
• Oversight of "white bagging" and "brown bagging"	
• Patient drug waste associated with mail order pharmacy dispensing processes	
• Improved appeal process	
Background Materials:	
• *Electronic Prior Authorization (ePA) National Adoption Scorecard* – provided by NCPA	36-51
Discussion of Topics for Next Meeting	
Adjourn	

******The workgroup will have a working lunch at approximately 12pm.******

Commonwealth of Virginia
Department of Health Professions
Pharmacy Benefit Manager Workgroup
Member List

David E. Brown, D.C., Director, Department of Health Professions

John Beckner, Senior Director, Strategic Initiatives, National Community Pharmacists Association

Geoffrey S. Ferguson, RPh, Pharmacist Lead, Anthem Blue Cross and Blue Shield

Douglas Gray, Executive Director, Virginia Association of Health Plans

William L. Harp, MD, Executive Director, Virginia Board of Medicine

Diana Jordan, Director, Division of Disease Prevention, Virginia Department of Health

Caroline D. Juran, Executive Director, Virginia Board of Pharmacy

Michael Jurgensen, Senior Vice President, Health Policy & Planning, Medical Society of Virginia

Rusty Maney, President, Virginia Association of Chain Drug Stores

Jessica S. Mazer, Esq., Assistant Vice President, State Affairs, Pharmaceutical Care Management Association

Timothy S. Musselman, Pharm.D., Executive Director, Virginia Pharmacists Association

Donna Proffitt, Pharmacy Manager, Virginia Department of Medical Assistance Services

Ellen B. Shinaberry, RPH PharmD, Member, Virginia Board of Pharmacy

John Sisto, Senior Director of Regulatory Affairs, Express-Scripts

Van Tompkins, Insurance Policy Advisor to the Commissioner, Virginia Bureau of Insurance

Kenneth J. Walker, MD, Member and President, Virginia Board of Medicine

Revised October 20, 2015

Commonwealth of Virginia
Department of Health Professions
Pharmacy Benefit Manager Workgroup
Member List

Sara Wilson, Director, Virginia Department of Human Resource Management

Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

Alternates:

T.C. Jones, IV, Supervisor, COPN, MCHIP & PRA Programs, Office of Licensure and Certification, Virginia Department of Health

Walter E. Norman, Program Manager, Virginia Department of Human Resource Management

Kirsten Roberts, Senior Policy Analyst, Medical Society of Virginia

Staff:

Laura Z. Rothrock, Executive Assistant & Operations Manager, Director's Office, Department of Health Professions

Commonwealth of Virginia
Department of Health Professions
Pharmacy Benefit Manager Workgroup

Monday, October 19, 2015
Perimeter Center, 2nd Floor Conference Center, Board Room 4
Henrico, Virginia

******DRAFT***MEETING MINUTES***

Members Present:

David E. Brown, D.C., Director, Department of Health Professions
John Beckner, Senior Director, Strategic Initiatives, National Community Pharmacists Association
Geoffrey S. Ferguson, RPh, Pharmacist Lead, Anthem Blue Cross and Blue Shield
Douglas Gray, Executive Director, Virginia Association of Health Plans
William L. Harp, MD, Executive Director, Virginia Board of Medicine (arrived at approximately 11:00am)
Caroline D. Juran, Executive Director, Virginia Board of Pharmacy
Michael Jurgensen, Senior Vice President, Health Policy & Planning, Medical Society of Virginia
Rusty Maney, President, Virginia Association of Chain Drug Stores
Jessica S. Mazer, Esq., Assistant Vice President, State Affairs, Pharmaceutical Care Management Association
Timothy S. Musselman, Pharm.D., Executive Director, Virginia Pharmacists Association
Donna Proffitt, Pharmacy Manager, Virginia Department of Medical Assistance Services
Ellen B. Shinaberry, RPH PharmD, Member, Virginia Board of Pharmacy
John Sisto, Senior Director of Regulatory Affairs, Express-Scripts
Van Tompkins, Insurance Policy Advisor to the Commissioner, Virginia Bureau of Insurance
Kenneth J. Walker, MD, Member and President, Virginia Board of Medicine
Sara Wilson, Director, Virginia Department of Human Resource Management (left at approximately 1:00pm)

Alternates Participating:

T.C. Jones, IV, Supervisor, COPN, MCHIP & PRA Programs, Office of Licensure and Certification, Virginia Department of Health

Members Absent:

Diana Jordan, Director, Division of Disease Prevention, Virginia Department of Health

Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

Staff Present:

Laura Z. Rothrock, Executive Assistant & Operations Manager, Director's Office, Department of Health Professions

Opening Remarks

Dr. Brown called the meeting to order at 9:13am. He welcomed the workgroup members and the public and gave a brief overview of the purpose of the workgroup. The workgroup members and staff introduced themselves.

Public Comment

Three individuals addressed the workgroup: John Lubkowski, Pharmacy Manager, Sentara; Tom La Martina, independent drug store owner, Brookneal Drug Company; and John Seymour, Pharmacist, Orange Pharmacy and Elkton Family Pharmacy. Workgroup members were given the opportunity to ask questions of the individuals.

Mr. Lubkowski discussed the relationship between a hospital oncology practice and pharmacy benefit managers (PBMs). PBMs require that the medications that patients receive come from a specialty pharmacy rather than the pharmacy where receiving treatment, and patients are told which specialty pharmacy to use. The difference between "Brown-bagging" and "White-bagging" was explained. Brown-bagging – ship medication to patient; Sentara does not allow. White-bagging – ship to hospital who mixes and dispenses to the patient; Sentara does allow. The following issues were discussed: 1) Patient safety – there can be delays in treatment. 2) Liability – Sentara does not have control of the medication before it gets to the hospital. 3) Risk in patient dosing and administration – especially when medication needs to be reconstituted or compounded. 4) Storage – PBMs will not accept medications back when a patient's treatment is stopped; Sentara is then responsible for disposal.

Mr. La Martina discussed lock-outs with PBMs (e.g., Anthem Healthkeepers, AARP, Cigna) which can be patient-specific or specific to a plan. Brookneal is losing customers because the customers are being forced to go somewhere else. This is not fair, and Mr. La Martina wants an equal playing field with the PBMs.

Mr. Seymour's main concern was patients' health care and what the PBMs are doing to interfere with it, particularly concerning access to specific pharmacies and denial of medication. PBMs, or their agents, will try to get patients to change who they are using to obtain their medications

(this is referred to as "slamming"). They will call the patient and encourage them to use a different pharmacy. Mr. Seymour indicated that 40% of patients with prior authorization approval will abandon that treatment. There is also a financial impact to patients because PBMs want name brands, not generics, to be used. As an independent pharmacist, Mr. Seymour is accountable to the Board of Pharmacy, and there is a need for accountability of the PBMs.

Workgroup Comments

Mr. Gray provided additional handouts which are included with these minutes (Virginia Code Sections from Title 38.2 - Insurance, Video: What is a Pharmacy Benefit Manager, and Tips for Self-Insured Plans).

Discussion took place concerning the reason for the creation of the workgroup (i.e., concerns expressed by Mr. John W. Frye of Rocky Mount, see Background Materials in the Agenda Package), whether or not CVS has a consistent credentialing process, and who has authority to investigate these types of complaints. Ms. Tompkins indicated that complaints to the Bureau of Insurance (BOI) are usually in reference to payment of claims, not credentialing.

Process for Credentialing Providers

Mr. Sisto outlined Express-Scripts' credentialing process and whether the process is the same for chains and independent pharmacies. There was discussion about fully-insured versus self-insured plans. Self-insured plans are regulated at the federal level, not the state. Virginia currently has no statutory authority over self-insured plans. Additional research is needed as to whether other states regulate the self-insured plans.

Oversight of PBMs

ERISA (Employee Retirement Income Security Act) is the law for self-insured plans. The BOI and the Virginia Department of Health (VDH) have no direct oversight for PBMs. The VDH does have authority over Managed Care Insurance Plans (MCIP). Prior authorization requirements can be found in Virginia Code §38.2-3407.15:3.

Process for Determining Drug Coverage

The use of Pharmacy and Therapeutics (P & T) Committees in determining drug coverage and the 2015 Federal Court ruling about ERISA and PBMs (handout provided by Mr. Musselman is included with these minutes) were discussed. Concerns include whether coverage decisions are being made by someone other than a clinician, what is considered medical necessity, and what is considered to be a specialty drug.

Board of Pharmacy Licensure/Regulation Issues

Currently, Mississippi is the only state with oversight of PBMs. A statutory change would be required in order for the Virginia Board of Pharmacy to regulate PBMs. The National Association of Boards of Pharmacy (NABP) Task Force recommendations on the regulation of PBMs (page 13 of the Agenda Package) were briefly discussed.

Topics to Consider for Future Meetings

1. White- and Brown-bagging appear to fall within alternate delivery requirements. A product is dispensed from one pharmacy to another to do something else with it (e.g., reconstitute or compound). If something goes wrong, who is liable? Legal clarification is needed.
2. What is a "specialty" drug? A definition and an idea of what constitutes one are needed. Ms. Mazer will look into this.
3. Pharmaceutical waste, especially regarding mail order
4. ERISA, especially degree to which it preempts state regulation
5. Assistance to pharmacists who have a complaint, and where they take that complaint.
6. Electronic prior authorization process. John Beckner will provide National Council for Prescription Drug Programs (NCPDP) information.

Dr. Brown indicated that the next meeting will be on November 13 and that it is possible the workgroup may finish it's discussions at that meeting. Any comments may be sent to Dr. Brown's attention.

The meeting was adjourned at 1:50pm.

Prepared By: Laura Z. Rothrock

From Doug Gray 10/19/2015
Attachment 1 to PBM Workgroup Minutes

Table of Contents

§ 38.2-3407.5. Denial of benefits for certain prescription drugs prohibited.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits will not be denied for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

B. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits will not be denied for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

C. For the purposes of subsections A and B:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means:

1. American Hospital Formulary Service Drug Information;

2. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or

3. Elsevier Gold Standard's Clinical Pharmacology.

D. Coverage, as described in subsections A and B, includes medically necessary services associated with the administration of the drug.

E. Subsections A and B shall not be construed to do any of the following:

1. Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the specific type of cancer or indication for which the drug has been prescribed;

2. Require coverage for experimental drugs not otherwise approved for any indication by the United States Food and Drug Administration;

3. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration;

4. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition; or

5. Require coverage for prescription drugs in any contract, policy or plan that does not otherwise provide such coverage.

F. The provisions of this section shall not apply to short-term travel, or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

G. The provisions of subsection A are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1994, and the provisions of subsection B are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1997.

1994, c. 374; 1997, c. 656; 2010, c. 443.

§ 38.2-3407.5:1. Coverage for prescription contraceptives.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis, shall offer and make available coverage thereunder for any prescribed drug or device approved by the United States Food and Drug Administration for use as a contraceptive.

B. No insurer, corporation or health maintenance organization shall impose upon any person receiving prescription contraceptive benefits pursuant to this section any (i) copayment, coinsurance payment or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment

level receiving benefits for prescription drugs, or (ii) reduction in allowable reimbursement for prescription drug benefits.

C. The provisions of subsection A shall not be construed to:

1. Require coverage for prescription coverage benefits in any contract, policy or plan that does not otherwise provide coverage for prescription drugs;

2. Preclude the use of closed formularies, provided, however, that such formularies shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods; or

3. Require coverage for experimental contraceptive drugs not approved by the United States Food and Drug Administration.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

E. The provisions of this section shall be applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1997.

1997, c. 748.

§ 38.2-3407.6:1. Denial of benefits for certain prescription drugs prohibited.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, an outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits shall not be denied for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

B. The provisions of this section shall not apply to short-term travel, or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

C. The provisions of this section are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999.

1999, c. 857.

§ 38.2-3407.7. Pharmacies; freedom of choice.

A. Notwithstanding any provision of § 38.2-3407 to the contrary, no insurer proposing to issue preferred provider policies or contracts shall prohibit any person receiving pharmacy benefits furnished thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are nonpreferred providers and that have previously notified the insurer, by facsimile or otherwise, of their agreement to accept reimbursement for their services at rates applicable to pharmacies that are preferred providers, including any copayment consistently imposed by the insurer, as payment in full. Each insurer shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure prompt verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonpreferred provider which has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonpreferred provider in excess of the copayment and the insurer's reimbursement applicable to all of its preferred pharmacy providers.

B. No such insurer shall impose upon any person receiving pharmaceutical benefits furnished under any such policy or contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred providers.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonpreferred provider and that has complied with subsection D or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on preferred providers.

D. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by an insurer, within 30 days of the pharmacy's receipt of the request, execute and deliver to the insurer the direct service agreement or preferred provider agreement that the insurer requires all of its preferred providers of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that insurer unless and until the pharmacy executes and delivers the agreement.

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

F. Nothing in this section shall limit the authority of an insurer proposing to issue preferred provider policies or contracts to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this subsection, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

1994, c. 963; 1995, c. 467; 2010, cc. 157, 357.

§ 38.2-3407.9:01. Prescription drug formularies.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the insurer, corporation, or health maintenance organization if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed pharmacists, physicians and other licensed health care providers.

B. If an insurer, corporation, or health maintenance organization maintains one or more closed drug formularies, each insurer, corporation, or health maintenance organization shall:

1. Make available to participating providers and pharmacists and to any nonpreferred or nonparticipating pharmacists as described in §§ 38.2-3407.7 and 38.2-4312.1, the complete, current drug formulary or formularies, or any updates thereto, maintained by the insurer, corporation, or health maintenance organization, including a list of the prescription drugs on the formulary by major therapeutic category that specifies whether a particular prescription drug is preferred over other drugs;

2. Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug if the formulary drug is determined by the insurer, corporation, or health maintenance organization, after reasonable investigation and consultation with the prescribing physician, to be an inappropriate therapy for the medical condition of the enrollee. The insurer, corporation or health maintenance organization shall act on such requests within one business day of receipt of the request; and

3. Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug when the enrollee has been receiving the specific nonformulary prescription drug for at least

six months previous to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific patient or that changing drug therapy presents a significant health risk to the specific patient. After reasonable investigation and consultation with the prescribing physician, the insurer, corporation or health maintenance organization shall act on such requests within one business day of receipt of the request. For purposes of this subsection, substituting the generic equivalent drug, which has been approved by the U.S. Food and Drug Administration, for a branded version of such drug shall not constitute a change in drug therapy.

C. Each insurer, corporation, or health maintenance organization that applies a formulary to the prescription drug benefits provided as set forth in subsection A shall provide to each affected group health benefit plan policyholder or contract holder or each affected individual health benefit plan policyholder or contract holder not less than 30 days' prior written notice of a modification to a formulary that results in the movement of a prescription drug to a tier with higher cost-sharing requirements. This section does not apply to modifications that occur at the time of coverage renewal.

1999, cc. 643, 649; 2000, c. 873; 2014, cc. 272, 297.

§ 38.2-3407.9:02. Requirement for prescription drug coverage.

No (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, or (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs shall exclude coverage for any prescription drug solely on the basis of the length of time since the drug obtained FDA approval.

2000, c. 508.

§ 38.2-3407.9:03. Payment of clean claims to administrators of pharmacy benefits.

A. As used in this section, "clean claim," "carrier," and "provider contract," shall have the meanings set forth in subsection A of § 38.2-3407.15.

B. Any contract between a carrier and its pharmacy benefits administrator or a carrier and a participating pharmacy, or its contracting agent, that requires claims be submitted electronically shall require that payment be made electronically to the participating provider or its designee for clean claims, as defined in subsection A of § 38.2-3407.15, submitted electronically. An electronic claim must be submitted in the form required by the carrier and in compliance with 45 CFR Part 142, as amended, provided that the participating provider or designee agrees to accept claims details for such payments electronically, in compliance with 45 CFR Part 142, as amended, and provides accurate electronic funds transfer information to the carrier.

C. This section shall apply with respect to contracts between a carrier and its pharmacy benefits administrator or a carrier and a pharmacy, or its contracting agent, that are entered into, amended, extended, or renewed on or after January 1, 2009.

2008, c. 104.

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) of this title or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (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) or 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); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1 of this title, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services

was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

6. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

7. Notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

8. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4 of this subsection) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

10. In the event that the carrier's provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and B 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title.

H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

I. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

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

1999, cc. 709, 739; 2004, c. 425; 2005, c. 349; 2014, cc. 157, 417; 2015, c. 709.

§ 38.2-3407.15:1. Carrier contracts with pharmacy providers; required provisions; limit on termination or nonrenewal.

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

"Audit" includes any audit conducted or authorized by a carrier or its intermediary to determine whether the participating pharmacy provider has complied with the terms and conditions for reimbursement under the provider contract.

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

"Clerical error" means any clerical or recordkeeping error or omission, such as typographical errors, scrivener's errors, or computer errors, in the keeping, recording, handling, or transcribing of pharmacy records. "Clerical error" does not include any clerical or recordkeeping error or omission that results in an overpayment by a carrier or its intermediary or the dispensing of a prescription in breach of applicable law or regulation.

"Fraud" means a knowingly or willfully false act of misrepresentation or an act in deliberate ignorance of the truth or falsity of the information as evidenced by a review of claims data, evaluation of provider statements, physical review of pharmacy records, or use of similar investigative methods by the carrier or its intermediary.

"Overpayment" means a payment by the carrier or its intermediary to the pharmacy provider that is greater than the rate or amount the provider is entitled to under the provider contract or applicable fee schedule.

"Pharmacy record" means a patient record, signature or delivery log, or prescription, including written, phoned-in, faxed, or electronic prescriptions, whether original or substitute, that complies with applicable law and regulation.

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

B. Any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to conduct audits of participating pharmacy providers, shall contain specific provisions that prohibit the carrier or intermediary, in the absence of fraud, from recouping amounts calculated from or arising out of any of the following:

1. Probability sampling, extrapolation, or other mathematical or statistical methods that allegedly project an error;

2. Clerical errors by the participating pharmacy provider;

3. An act or omission of the participating pharmacy provider that was not specifically prohibited or required by the provider contract when the claim was adjudicated unless the act or omission was a violation of applicable law or regulation;

4. The refusal of a carrier or its intermediary to consider during an audit or audit appeal a pharmacy record in electronic form to validate a claim;

5. Dispensing fees or interest on the claim, except in the event of an overpayment, if the prescription was dispensed in accordance with applicable law or regulation;

6. Any claim authorized and dispensed more than 24 months prior to the date of the audit unless the claim is adjusted at the direction of the Commission, except that this time period shall be tolled while the denial of the claim is being appealed;

7. An alleged breach of auditing requirements if they are not the same as the requirements that the carrier or intermediary applies to other participating pharmacy providers in the same setting;

8. The refusal of the carrier or its intermediary to consider during an audit or audit appeal a pharmacy record, a prescriber or patient verification, or a prescriber record to validate a claim; or

9. The alleged failure of the participating pharmacy provider to supply during an audit or audit appeal a pharmacy record not specifically identified in the provider contract.

C. Any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to conduct audits of participating pharmacy providers, shall contain specific provisions that prohibit the carrier or intermediary, in the absence of fraud by the participating pharmacy provider, from terminating or failing to renew the contractual relationship with a participating pharmacy provider for invoking its rights under any contractual provision required to be contained in the contract pursuant to subsection B.

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

E. This section shall apply with respect to contracts described in subsection B or C entered into, amended, extended, or renewed on or after January 1, 2015.

2014, c. 308.

§ 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 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 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 or his designee, within two business days of submission 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; 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.

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.

2015, cc. 515, 516.

§ 38.2-3407.15:3. Carrier and intermediary contracts with pharmacy providers; disclosure and updating of maximum allowable cost of drugs; limit on termination or nonrenewal.

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.

"Maximum allowable cost" means the maximum dollar amount that a carrier or its intermediary will reimburse a pharmacy provider for a group of drugs rated as "A", "AB", "NR", or "NA" in the most recent edition of the Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, published by the U.S. Food and Drug Administration, or similarly rated by a nationally recognized reference.

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

B. Any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to establish a maximum allowable cost, shall contain specific provisions that require the intermediary or carrier to:

1. Update, not less frequently than once every seven days, the maximum allowable cost list, unless there has been no change to the maximum allowable cost of any drug on the list since the last update;

2. Verify, not less frequently than once every seven days, that the drugs on the maximum allowable cost list are available to participating pharmacy providers from at least one regional or national pharmacy wholesaler and that the amount for each drug is not obsolete and promptly revise the maximum allowable cost if necessary to comply with this subsection;

3. Provide a process for each participating pharmacy provider to readily access the maximum allowable cost list specific to that provider; and

4. Prohibit the intermediary or carrier from terminating or failing to renew its contractual relationship with a participating pharmacy provider for invoking its rights under any contractual provision required by this section.

C. Any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to establish a maximum allowable cost, shall contain specific provisions that require the intermediary or carrier to provide a process for an appeal, investigation, and resolution of disputes regarding maximum allowable cost drug pricing that includes:

1. A time period of 14 days from the date of initial claim adjudication for the participating pharmacy provider to file its dispute request;

2. A requirement that the dispute request be investigated and resolved within 14 days of its initiation by the participating pharmacy provider;

3. A telephone number at which the participating pharmacy provider may contact the carrier or its intermediary to speak to a person responsible for processing dispute requests;

4. A requirement that a carrier or its intermediary, if a dispute request is denied, provide (i) a reason for the denial, and (ii) the national drug code of the drug under dispute that the carrier or its intermediary contends may be purchased by the participating pharmacy provider for an amount that is equal to or less than the maximum allowable cost; and

5. A requirement that a carrier or its intermediary, if a dispute is successful, update the maximum allowable cost for the drug under dispute within five days of the determination of the dispute.

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

E. This section shall apply with respect to contracts described in subsections B and C entered into, amended, extended, or renewed on or after January 1, 2016.

2015, c. 518.

§ 38.2-3407.18. Requirements for orally administered cancer chemotherapy drugs.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts, or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts, or plans, include coverage for cancer chemotherapy drugs administered orally and intravenously or by injection shall provide that the criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made, on and after the effective date of this section. The provisions of this section shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

C. This section shall apply to health coverage offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, local officers, teachers and retirees pursuant to § 2.2-1204. In administering such coverage, the criteria for establishing the level of copayments or coinsurance for orally administered cancer treatment drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

2012, cc. 634, 641; 2014, c. 814.

§ 38.2-3451. Essential health benefits.

A. Notwithstanding any provision of § 38.2-3431 or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or small group health insurance coverage shall provide that such coverage includes the essential health benefits as required by § 1302(a) of the PPACA. The essential health benefits package may also include associated cost-sharing requirements or limitations. No qualified health insurance plan that is sold or offered for sale through an exchange established or operating in the Commonwealth shall provide coverage for abortions, regardless of whether such coverage is provided through the plan or is offered as a separate optional rider thereto, provided that such limitation shall not apply to an abortion performed (i) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (ii) when the pregnancy is the result of an alleged act of rape or incest.

B. The provisions of subsection A regarding the inclusion of the PPACA-required minimum essential pediatric oral health benefits shall be deemed to be satisfied for health benefit plans made available in the small group market or individual market in the Commonwealth outside an exchange, as defined in § 38.2-3455, issued for policy or plan years beginning on or after January 1, 2015, that do not include the PPACA-required minimum essential pediatric oral health benefits if the health carrier has obtained reasonable assurance that such pediatric oral health benefits are provided to the purchaser of the health benefit plan. The health carrier shall be deemed to have obtained reasonable assurance that such pediatric oral health benefits are provided to the purchaser of the health benefit plan if:

1. At least one qualified dental plan, as defined in § 38.2-3455, (i) offers the minimum essential pediatric oral health benefits that are required under the PPACA and (ii) is available for purchase by the small group or individual purchaser; and

2. The health carrier prominently discloses, in a form approved by the Commission, at the time that it offers the health benefit plan that the plan does not provide the PPACA-required minimum essential pediatric oral health benefits.

2013, c. 751; 2014, cc. 307, 369.

§ 38.2-4209.1. Pharmacies; freedom of choice.

A. Notwithstanding any provision of § 38.2-4209, no corporation providing preferred provider subscription contracts shall prohibit any person receiving pharmaceutical benefits thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are nonpreferred providers and that have previously notified the corporation, by facsimile or otherwise, of their agreement to accept reimbursement for their services at rates applicable to pharmacies that are preferred providers, including any copayment consistently imposed by the corporation, as payment in full. Each corporation shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure payment verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonpreferred provider which has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonpreferred provider in excess of the copayment and the corporation's reimbursement applicable to all of its preferred pharmacy providers.

B. No such corporation shall impose upon any person receiving pharmaceutical benefits furnished under any such contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred providers.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonpreferred provider and that has complied with subsection D or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on preferred providers.

D. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by a corporation, within 30 days of the pharmacy's receipt of the request, execute and deliver to the corporation the direct service agreement or preferred provider agreement that the corporation requires all of its preferred providers of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that corporation unless and until the pharmacy executes and delivers the agreement.

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

F. Nothing in this section shall limit the authority of a corporation issuing preferred provider policies or contracts to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this subsection, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

1994, c. 963; 1995, c. 467; 2010, cc. 157, 357.

§ 38.2-4312.1. Pharmacies; freedom of choice.

A. Notwithstanding any other provision in this chapter, no health maintenance organization providing health care plans shall prohibit any person receiving pharmaceutical benefits thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are not participating providers under any such health care plan and that have previously notified the health maintenance organization, by facsimile or otherwise, of their agreement to accept reimbursement for their services at rates applicable to pharmacies that are participating providers, including any copayment consistently imposed by the plan, as payment in full. Each health maintenance organization shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure prompt verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonparticipating provider which has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonparticipating provider in excess of the copayment and the health maintenance organization's reimbursement applicable to all of its participating pharmacy providers.

B. No such health maintenance organization shall impose upon any person receiving pharmaceutical benefits furnished under any such health care plan:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are not participating providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are not participating providers.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonparticipating provider and that has complied with subsection E or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on participating providers.

D. The provisions of this section are not applicable to any pharmaceutical benefit covered by a health care plan when those benefits are obtained from a pharmacy wholly owned and operated by, or exclusively operated for, the health maintenance organization providing the health care plan.

E. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by a health maintenance organization, within 30 days of the pharmacy's receipt of the request, execute and deliver to the health maintenance organization the direct service agreement or participating provider agreement that the health maintenance organization requires all of its participating providers of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that health maintenance organization unless and until the pharmacy executes and delivers the agreement.

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

G. Nothing in this section shall limit the authority of a health maintenance organization providing health care plans to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this subsection, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

1994, c. 963; 1995, cc. 446, 467; 2010, cc. 157, 357.

§ 38.2-5805. Provider contracts.

A. Each health carrier subject to subsection B of § 38.2-5801 shall file with the Commission a list of the current providers who have executed a contract directly with the health carrier or indirectly through an intermediary organization for the purpose of providing health care services pursuant to an MCHIP or for the benefit of a covered person of an MCHIP. The list shall include the names and localities of the providers. The list shall be updated by the health carrier at least annually and more frequently as required by the Commission in accordance with provisions in this title or by the State Health Commissioner in accordance with provisions in Title 32.1.

B. Every contract with a provider of health care services enabling an MCHIP to provide health care services shall be in writing.

C. When the health carrier is a health maintenance organization, the contracts with providers enabling the MCHIP to provide health care services to the covered persons shall contain a "hold harmless" clause setting forth that, in the event such health carrier fails to pay for health care services as set forth in the contract, the covered persons shall not be liable to the provider for any sums owed by the health carrier. The following requirements shall apply to such contracts:

1. Such contracts shall require that if the provider terminates the agreement, the provider shall give the health carrier at least sixty days' advance notice of termination.

2. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier.

3. If there is an intermediary organization enabling a health carrier subject to subsection B of § 38.2-5801 to provide health care services by means of the intermediary organization's own contracts with health care providers, the contracts between the intermediary organization and its providers shall be in writing.

4. The contracts shall set forth that, in the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the health carrier.

5. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization.

6. An agreement to provide health care services between an intermediary organization and a health carrier subject to subsection B of § 38.2-5801 shall require that if the intermediary organization terminates the agreement, the intermediary organization shall give the health carrier at least sixty days' advance notice of termination.

7. An agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination.

8. Each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract.

9. The "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. The health carrier may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to the covered persons.

Hold Harmless Clause

[Provider] hereby agrees that in no event, including, but not limited to nonpayment by the MCHIP or its health carrier, the insolvency of the [health carrier], or breach of this agreement, shall [Provider] bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against subscribers or persons other than the health carrier for services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the subscriber agreement for the MCHIP.

[Provider] further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the plan's subscribers and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between [Provider] and the subscriber or persons acting on the subscriber's behalf.

10. If there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause set forth in subdivision 5 shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization.

D. The Commission may specify for each type of health carrier other than a health maintenance organization the circumstances, if any, under which a health carrier for an MCHIP shall contract with a provider with the "hold harmless" clause described in subsection C. The Commission may specify also the extent to which certain accounting treatment, reserves, net worth or surplus shall be required for liabilities arising from provider contracts without the "hold harmless" clause.

1998, c. 891.

From Doug Gray 10/19/2015
Attachment 2 to PBM Workgroup Minutes

OCT 8, 2015

VIDEO: What is a Pharmacy Benefit Manager?

Express Scripts puts medicine within reach of tens of millions of people by aligning with our clients, taking bold action and delivering patient-centered care to make better health more affordable and accessible.

WHAT IS A PBM?

At Express Scripts, we work with plan sponsors to provide a benefit that delivers the best clinical outcome and the lowest possible cost.

This means making sure the right medication gets to the right patient at the right time.

Employers, unions and government organizations throughout the nation rely on our services. We are in their corner to negotiate with drug manufactures so no one pays more than they need to. Any dollar spent that doesn't improve health is a dollar wasted.

Ensuring Access, Safety and Savings

PBMs drive waste out of the system, while ensuring patient safety.

When a patient fills a prescription, Express Scripts pharmacists are working behind the scenes to review prescription history, ensure correct dosing, check for potential drug interactions and make sure the medication is affordable.

And, compassionate care (/insights/pharmacy-options/video-how-express-scripts-practices-pharmacy) is just a phone call away – any day, any time.

Another way PBMs add value is by reviewing the thousands of drugs have been approved for use. An independent panel of physicians and pharmacist takes a close look at the drugs and provides a formulary (/insights/drug-options/how-we-build-a-formulary) – a list of medications proven to provide the best clinical results for all conditions.

By delivering smarter solutions to patients and clients, PBMs provide better care and lower cost with every prescription, every time.

AUTHOR Bio

LAB STAFF
(/about/contributors/lab-staff)

From Doug Gray 10/19/2015
Attachment 3 to PBM Workgroup Minutes

Tips for Self-Insured Plans

Tips to Help You Understand and Appeal Health Plan Decisions When the Coverage is Self-Insured

If your coverage for health care is provided through your employer, it is very important to know if the coverage is self-insured or fully-insured. If the coverage is fully-insured, the Virginia Bureau of Insurance or other state insurance department may address any problems that you have. If the coverage is self-insured, then problems will need to be addressed by the Department of Labor (DOL), an agency of the federal government. The following information will help you determine if your coverage is fully-insured or self-insured.

KEY TERMS YOU SHOULD KNOW

Managed Care Health Insurance plan (MCHIP) – a health carrier, such as a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), that designs arrangements to provide covered services in an efficient and cost-effective manner, to help control the cost of your coverage.

Group Health Insurance – health insurance provided by an employer to employees and in some cases family members, and paid for by the employer, the employees, or both; coverage may be through an MCHIP or other type of health insurance.

Fully-insured – group health insurance where an employer pays a premium to an MCHIP or other insurer and in return, the MCHIP or insurer assumes the financial risk of paying claims. There is an insurance contract between the employer and the MCHIP or other insurer.

Self-insured – group coverage where the employer acts as its own insurer, and uses an MCHIP, "insurer", or administrator to administer the plan: establish a provider network, process claim payments, and conduct other tasks necessary to run the plan. There is no insurance contract between the employer and the administrator because the employer bears the risk for payment of claims.

ERISA – Employee Retirement Income Security Act that Congress passed in 1974 that provides exclusive federal jurisdiction over single employer benefit plans, including self-insured plans.

DOL – U.S. Department of Labor, part of the federal government and responsible for ensuring employers comply with ERISA.

To determine if your health care coverage is fully-insured or self-insured, check with the Benefits Administrator or Plan Administrator in your employer's Human Resource office. You may also find clues in documents provided by the plan in any language that states the plan is only acting as an administrator or providing "administrative services only" to the employer.

Large companies frequently self-insure for a variety of reasons, including consideration of the costs involved. Some large companies offer both self-insured and fully-insured coverage, so be sure to check for your specific coverage.

If you have a dispute with a self-insured plan, state regulatory agencies like the Bureau of Insurance will not be able to formally assist you, because ERISA gives the federal government exclusive regulatory jurisdiction over self-insured plans. Since there is no insurance contract between the employer and administrator in a self-insured plan, the Bureau of Insurance cannot intervene because it only regulates insurance companies. The Bureau of Insurance does not

regulate employers. You can seek assistance from your employer by contacting the Plan Administrator or Benefit Administrator. In addition, you can contact the DOL for assistance:

U.S. Department of Labor
Employee Benefits and Security Administration
Washington District Office
1335 East-West Highway, Suite 200
Silver Spring, Maryland 20910
(Phone: 301-713-2000)
(Toll-free: 866-444-EBSA (3272))
(Fax: 301-713-2008)
(Website: www.dol.gov/ebsa)

Self-insured plans also provide a way for individuals covered under the plan to file appeals through the internal appeal procedure available with that particular plan.

Along with exemption from regulatory jurisdiction by the Bureau of Insurance, self-insured plans are exempt from Virginia insurance laws, including those that pertain to mandated benefits, appeals, and consumer rights.

From Tim Musselman 10/19/2015 Attachment 4 to PBM Workgroup Minutes.

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

An Important 2015 Federal Court Ruling Confirms:

ERISA Does Not Prevent State Regulation of Pharmacy Benefits Managers

As a frequent scare tactic, Pharmacy Benefit Managers (PBMs) and their national trade association, PCMA, inaccurately argue that any State regulation of PBMs is preempted by the federal Employee Retirement Income Security Act, otherwise referred to as ERISA. Recently a federal judge found this to not be the case. The following summarizes the background and specific findings of that decision.

- February 18, 2015: A federal court in Iowa squarely rejected PBM claims regarding ERISA preemption. *See PCMA v. Gerhart*, No. 4:14-cv-345 (S.D. Iowa)

- At issue was an Iowa law that places important reforms on the inequitable practices of PBMs—practices that have not only harmed pharmacists, but also their customers by threatening the availability of needed prescription drugs.

- More specifically, the Iowa law that was challenged requires PBMs to—
  - Disclose certain pricing information to the Iowa Insurance Commissioner upon request;
  - Use nationally-recognized data when setting maximum reimbursement amounts for certain drugs; and;
  - Implement an appeal process that allows pharmacies to challenge the cost methodologies of PBMs.

- PCMA brought a lawsuit in federal district court challenging the Iowa law, arguing among other claims, that the law conflicts with and is preempted by the ERISA.

- The court rejected these arguments, and in the process, debunked many of the myths that PCMA has commonly circulated about ERISA preemption over PBM reform issues.

- **Specifically, the court held:**
  - **State regulation of PBMs is not preempted by ERISA where that law—**
    - **"does not require a particular price for any drug."**
    - **"does not set a pricing methodology for any drug"**
    - **"does not unduly restrict the administration of any ERISA plan."**

  - State regulation of PBMs does not have an impermissible "reference to" ERISA where it "does not 'act immediately and exclusively upon ERISA plans' and 'the existence of ERISA plans' is not 'essential to the law's operation.'"

  - State regulation mandating certain disclosure requirements by PBMs does not conflict with ERISA's disclosure requirements. Whereas ERISA requires certain disclosures that administrators must provide to "participants and beneficiaries," the Iowa law provides for disclosures between PBMs and the Insurance Commissioner and pharmacists. Accordingly, there is no conflict.

In short, ERISA does not prevent States from enacting meaningful legislation necessary to reign in the inequitable conduct of PBMs.

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OCTOBER 2015

NATIONAL ADOPTION SCORECARD

Electronic Prior Authorization (ePA)

This report summarizes the current state of the electronic prior authorization (ePA) industry. The intent is to quantify current ePA adoption rates, highlight implementation status by market share leaders, and outline the keys to success for ePA in the industry.

epascorecard.covermymeds.com

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The ePA National Adoption Scorecard is written and published by CoverMyMeds® with guidance from industry experts on the ePA National Adoption Scorecard Advisory Board:

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Cerner Corporation, Senior Strategist, Clinical Solutions Management

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VA Association of Health Plans, Executive Director

A NOTE FROM BECKY SNEAD, EVP AND CEO OF NASPA

The National Alliance of State Pharmacy Associations (NASPA) mission is to enhance the success of state pharmacy associations in their effort to advance the profession of pharmacy. NASPA's membership is comprised of State Pharmacy Associations and more than 70 stakeholder affiliate members.

These stakeholders work together to address pharmacy industry interests and support initiatives that improve patient health care. NASPA supports leadership, sharing, learning and policy exchange among its members and pharmacy leaders nationwide.

NASPA and its members remain actively involved in advocacy and educating state and federal legislators and agency personnel on health care related issues that are critical for providers and pharmacists, but most importantly, patients. A few of the issues addressed recently include:

- Collaborative Practice Agreements
- Combating Rx Abuse
- Immunizations
- Specialty Drugs and Specialty Pharmacy
- E-Prescribing
- Electronic Prior Authorization (ePA)

As a pharmacist and advocate for the industry, specifically an advocate for the patient, I have seen the frustration from all parties when a prescription is denied due to cumbersome policies and procedures related to prior authorization. While the intent of prior authorization (PA) is warranted, the archaic, paper process causes undue administrative waste for health care professionals and delays patient treatment. Often, the result is prescription abandonment, which ultimately results in additional costs to the health care industry.

The need for ePA is real and now is the time to implement a streamlined, electronic PA process. This report, which my peers and I have provided feedback and guidance on, outlines the status of ePA and the steps necessary to successfully implement ePA across the industry.

My involvement in the ePA National Adoption Scorecard represents my commitment to improving the PA process through electronic prior authorization.

We hope you will join us in moving the industry toward 100% ePA adoption.

Executive Summary

OVERVIEW

The ePA National Adoption Scorecard details the current state of electronic prior authorization (ePA). The Scorecard follows the increase in ePA availability in electronic health records (EHR) systems with payers and at pharmacies, which represent the majority of the market share. The original ePA National Adoption Scorecard report was published in March 2015; it is updated and republished semiannually.

In addition to availability updates, this release of the report includes new information on ePA legislation by state.

METHODOLOGY

The ePA National Adoption Scorecard compiles data from several publications as listed in the sources section of this report. Availability data is based on public announcements as well as direct communication from companies. Where noted, CoverMyMeds' connections to more than 360 EHRs, all payers, and 45,000 pharmacies, is used to supplement and advise key takeaways.

Companies interested in working with the CoverMyMeds research team, or updating report data, may contact epascorecard@covermymeds.com.

SUMMARY OF ePA AVAILABILITY

ePA availability changes often as EHR systems, payers and pharmacies work with ePA vendors to make functionality available to end users. As of the third quarter (Q3) 2015, the current availability of ePA is as follows:

- EHR and E-Prescribing: 70% committed, 47% available, 47% live
- Payers: 87% committed, 68% available, 68% live
- Pharmacies: 83% committed, 82% available, 72% live

ePA: CRITICAL FOR THE HEALTH CARE INDUSTRY

Prior authorization (PA) was implemented years ago to provide the most appropriate and cost-effective health care services. The traditional paper-based PA process results in administrative waste and abandonment of prescriptions by patients.

- PA costs the industry billions of dollars annually.
- Prescribers and their staff spend more than 20 hours per week on PA requests.
- 40% of PA requests are abandoned because of complex policies and procedures.

These challenges make it critical that the health care industry adopt a solution that creates cost and administrative efficiencies and ensures patients are not lost in the PA process.

Electronic prior authorization provides real-time information to all participants in the PA decision-making process through interconnectivity.

CoverMyMeds data demonstrates that the use of ePA significantly reduces the time spent on each PA request, up to 80%, from as many as 15 to 20 minutes to as few as 3 to 5 minutes. Turnaround time of a PA is decreased from 3 to 5 business days to within hours in most cases and mere moments when auto-determination is leveraged.

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EARLY ePA SUCCESS

Although the idea of ePA has existed for years, only now is the industry experiencing the positive impact of a more efficient electronic solution.

One example is a regional health plan serving millions of members. The plan, which implemented ePA in June 2014, decreased PA reviews by 40% and increased auto-determinations by 35% as a result of ePA functionality powered by CoverMyMeds. More than half of the plan's prescribers currently use ePA.

RECOMMENDATION

To create the best PA process for the industry, we recommend swift and complete ePA adoption by EHR vendors, payers and pharmacies leveraging functionality from ePA vendors outlined in the key success factors section of this report.

ePA NATIONAL ADOPTION SCORECARD

This scorecard was developed to communicate the current status of ePA in the industry, highlight trends and indicate what is required to achieve success in industry-wide ePA adoption.

It was developed in collaboration with an advisory board of industry experts. Those participating are listed at the top of the scorecard and we personally want to thank them for their efforts, time, edits and recommendations throughout this process.

About ePA

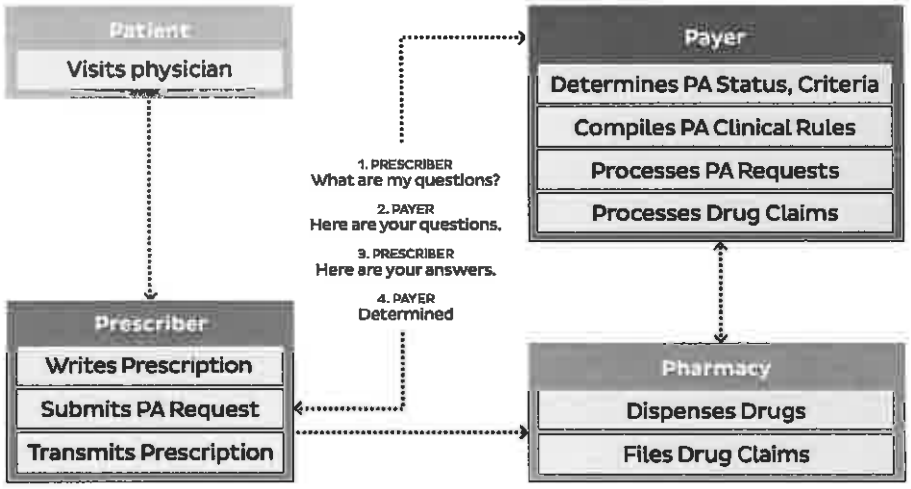
Electronic prior authorization is the automated process of exchanging prior authorization requirements and connecting the various organizations participating in the process.

ePA PROCESS [1]

Today, many PA requests are completed through a manual process that involves phone calls and faxes back and forth between the pharmacy, the prescriber and the health plan. This is an inefficient process that can lead to the patient abandoning the prescription.

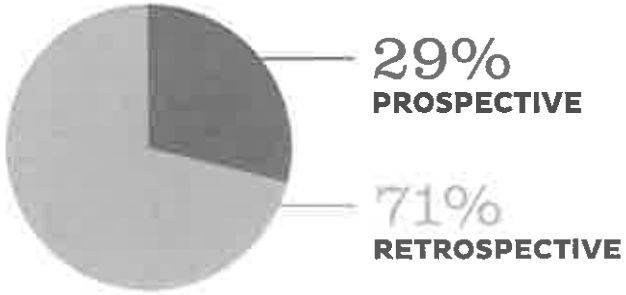
Electronic prior authorization automates this process by allowing the prescriber to initiate the ePA within their prescribing workflow. The most successful ePA strategies also connect the pharmacy to initiate an ePA that was missed at the point of prescribing.

The ePA process involves a four-part transaction that enables patient-specific and drug-specific PA criteria and a real-time approval process.

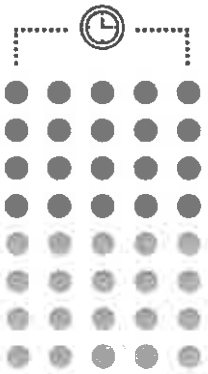


1 - Adapted from NCPDP SCRIPT Standard Electronic Prior Authorization Transactions Overview, August 2013

This graph illustrates prospective vs. retrospective PA requests processed by CoverMyMeds, the majority of which are started at the pharmacy. [2]

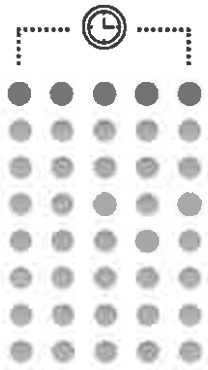


The percentage of prospective requests includes those started by the pharmacy outside of an electronic workflow, which results in the appearance of being prospective when it was initiated by the prescriber through CoverMyMeds. Therefore, the actual percentage is likely much smaller than 29%.



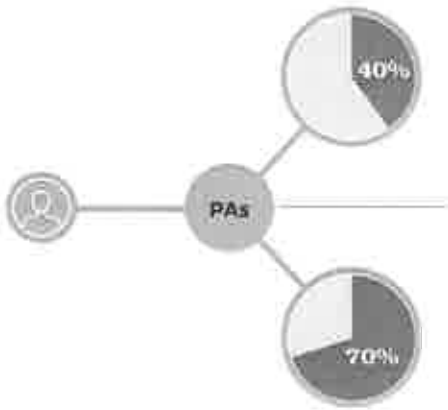
More than half of prescribers indicate they and their staff spend up to 20 hours per week on PA requests

Nationwide, physicians spend $37 billion annually interacting with health plans. Much of that cost is directly related to prior authorization and medication formulary requirements. [3]



Pharmacists spend an average of 5 hours per week on PA requests

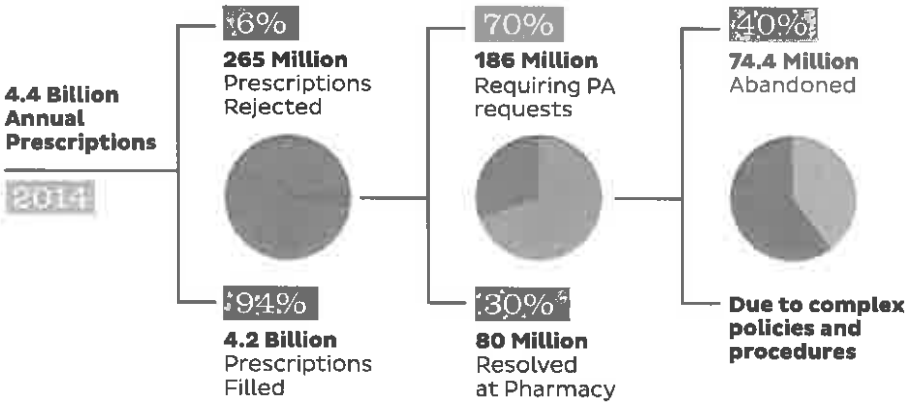
2 - CoverMyMeds Data
3 - Health Affairs "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers"



Nearly 40% of PA requests are abandoned due to complex procedures and policies. [4]

Nearly 70% of patients encountering paper-based PA requests do not receive the original prescription. [4]

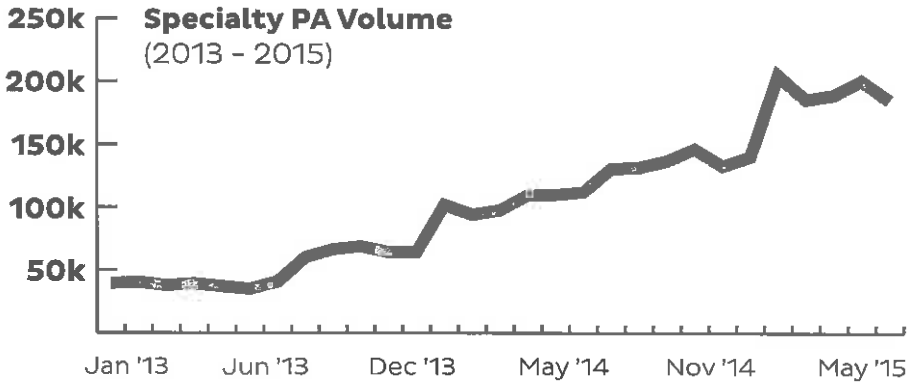
Recent studies indicate 265 million claims per year are rejected, resulting in 74.4 million abandoned prescriptions. PA volume is increasing by more than 20%+ per year. [5]



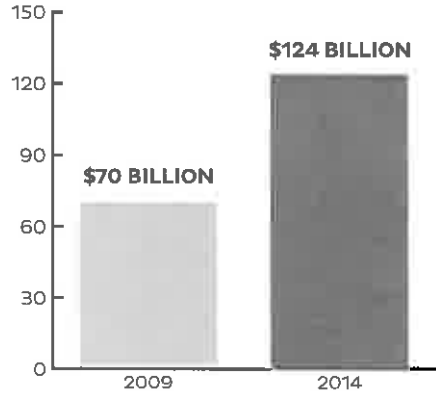
4 - Based on Frost & Sullivan study
5 - Administration on Aging: The Next Four Decades, The Older Population in the United States: 2010 to 2050

SPECIALTY MEDICATIONS

There is a direct correlation between the availability of specialty and new medications and a rise in PA volume. As more specialty medications enter the market the industry will see an increase in the need for PA requests.

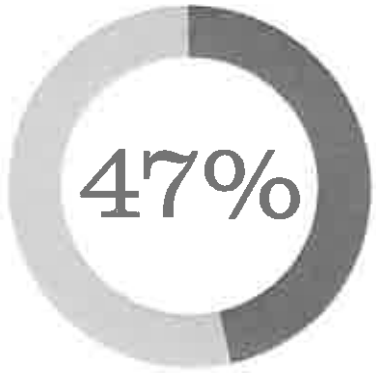


SPECIALTY MEDICATION SPENDING[6]



In 2014, more than $124 billion was spent on specialty medication, a $54 billion increase since 2009.

NEW MEDICATION SPENDING[6]



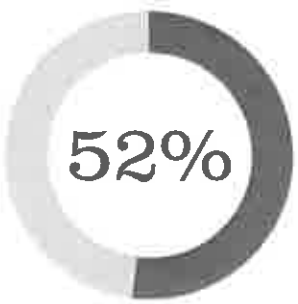
New medication accounted for $20 billion, or 47%, of total medication spending growth in 2014.

2 - CoverMyMeds Data
6 - "Specialty Drugs, Medicaid Expansion Drive Jump in Prescription Spending," Modern Healthcare, April 2015

MEDICAID

Elderly and disabled patients who account for 52% of Medicaid spending are more likely to need medications that require prior authorization due to chronic and behavioral conditions.

It's estimated that states will or have added more than 500,000 adults with serious behavioral health issues to their covered Medicaid population. [7]



MEDICAID SPENDING

The Medicaid program can realize cost savings by leveraging ePA either through integration with Managed Medicaid Information Systems, or by requiring ePA from contracted Managed Care Organizations. Currently, only NM Medicaid, Medicaid benefits in Illinois covered by BCBSIL and Medicaid programs in Florida and North Carolina served by US Script offer ePA.[2]

ePA reduces the time spent on each PA request up to 80%, from as many as 15 to 20 minutes to as few as 3 to 5 minutes. Turnaround time of a PA request is decreased from as many as 3 to 5 business days to within hours in most cases and mere moments when auto-determination is leveraged. [2]

	PRE-ELECTRONIC	ELECTRONIC FAX	EPA
Completion	15-20 Mins.	3-5 Mins	Portal: 3-5 Mins. EHR: Seconds
Turnaround Time	3-5 Days	2-4 Days	Approved: Often real-time Denied: Less than 24 hours

2 - CoverMyMeds Data
7 - Non-Emergency Medical Transportation: A Vital Lifeline For a Healthy Community

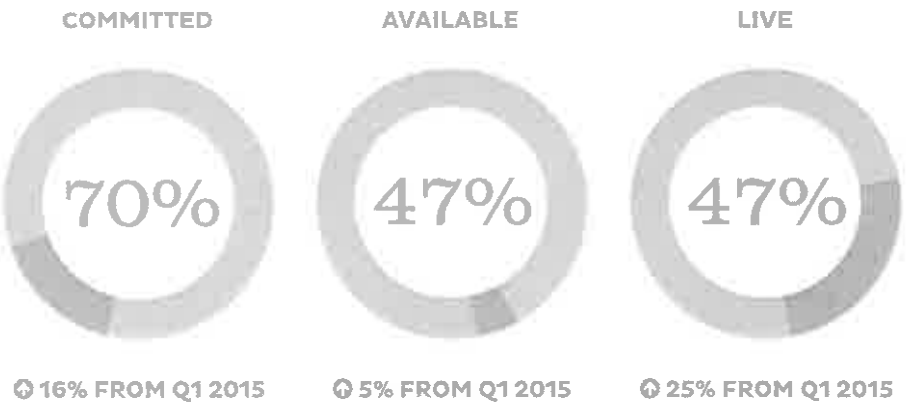
ePA Availability Status by EHR Vendors

INTRODUCTION

The integration of ePA within EHR systems is potentially transformative to prescribers and their staff by providing a way to efficiently and effectively participate in PA within their workflow.

Realizing this potential is largely dependent on supporting retrospective, prospective and all-payer capabilities. ePA integrations that incorporate these capabilities essentially eliminate the need for paper PA forms. Integrations that are missing one or more of these capabilities will still require physicians and their staff to use multiple methods for completing PA requests.

Percentage of EHR market committed to ePA and implementation status as of Q3 2015*



*Details companies representing the majority of market share.[8] This report may be updated with additional information provided by EHR vendors. Vendors can submit information to epascorecard@covermymeds.com.

EHR	COMMITTED	AVAILABLE	LIVE	COMPLETENESS
Allscripts	●	●	●	⟲ ⟳
AmazingCharts	○	○	○	⟲
athenahealth	○	○	○	
Cerner Updated	●	○	○	⟲
DrFirst	●	●	●	⟲ ⟳ ◧
eClinicalWorks Updated	●	○	○	⟲ ⟳
e-MDs	○	○	○	⟲
Epic Systems Updated	●	●	●	⟲ ⟳ ◧
GE Healthcare	○	○	○	⟲ ⟳
Greenway Health	○	○	○	⟲
McKesson	○	○	○	⟲
Meditech	○	○	○	⟲
NewCrop	●	●	●	⟲ ⟳ ◧
NextGen Healthcare	●	○	○	⟲
Practice Fusion Updated	●	●	●	⟲ ⟳ ◧

KEY

Committed = The company publicly announced they are committed to implementing an ePA solution.

Available = The company and the ePA vendor completed the integration work required for the ePA solution.

Live = The ePA solution is operational in a production environment.

⟲ EHR includes retrospective PA functionality

⟳ EHR includes prospective PA functionality

◧ Requests completed through EHR can be submitted to any payer

KEY TAKEAWAYS

EHRs representing 70% of the market share are committed to implementing ePA, a 16% increase from Q1 2015. The largest EHRs are rapidly prioritizing ePA.

Between Q1 and Q3 2015, EHRs with live functionality increased significantly—from initially 22% to currently 47%.

Only two listed EHR or E-Prescribing vendors are live with retrospective capabilities. Several others are incorporating this functionality now and will be live soon. CoverMyMeds data indicates in 2014, 71% of PA requests were initiated at the pharmacy, whereas only 29% were initiated by a prescriber. Until more prescribers have access to and adopt a viable prospective ePA capability in their EHR system, retrospective capability will remain a key driver of ePA adoption.

8 - Software Advice - EHR Meaningful Use Market Share Industry View 2014
9 - SK&A - Physician Office Usage of Electronic Health Records Software

ePA Availability Status by Payers

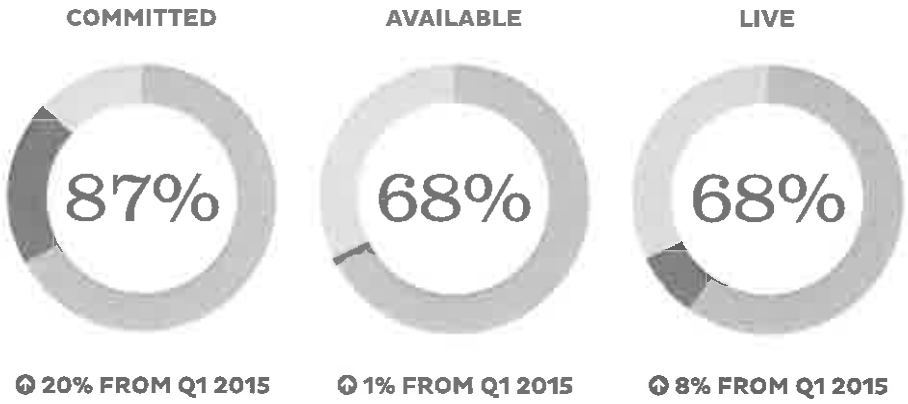
INTRODUCTION

Payer integration of ePA functionality ensures all PA requests, regardless of the submission source (e.g., pharmacy system, web portal or EHR), may be reviewed and determined electronically. For payers, ePA eliminates manual entry of faxed or phoned PA requests, enables payers to receive complete information on initial submission, and eliminates determination faxes to prescribers and pharmacies.

Auto-determination functionality helps payers auto-review requests and provide real-time determinations based on preset criteria. In many cases, prescribers receive the outcome within moments of submission.

Indicating a payer is live with ePA does not mean all medications or plans—in the case of a PBM—use ePA functionality. The majority of payers activate ePA for a select number of medications or plans that they service. Transitioning a payer to ePA requires electronic incorporation of all criteria, which differs by plan and medication.

Percentage of payers committed to ePA and implementation status as of Q3 2015*



▲ 20% FROM Q1 2015 ▲ 1% FROM Q1 2015 ▲ 8% FROM Q1 2015

*Details companies representing the majority of market share.[10] This report may be updated with additional information provided by payers. Vendors can submit information to epascorecard@covermymeds.com.

PAYER	COMMITTED	AVAILABLE	LIVE
Aetna	●	●	●
Argus Health Systems Updated	●	●	○
Catamaran	●	○	○
Cigna-HealthSpring	●	●	●
CVS/caremark	●	●	●
Express Scripts	●	●	●
EnvisionRx Updated	●	●	●
Humana	●	●	●
Magellan Rx Updated	●	○	○
MedImpact	○	○	○
OptumRx Updated	●	●	●
PerformRx	○	○	○
Prime Therapeutics	●	●	●
US Script	●	●	●
Xerox	○	○	○

KEY

Committed = The company publicly announced they are committed to implementing an ePA solution.
Available = The company and the ePA vendor completed the integration work required for the ePA solution.
Live = The ePA solution is operational in a production environment.

10 – AIS's Pharmacy Benefit Survey

KEY TAKEAWAYS

87% of payers representing the majority of market share are committed to implementing ePA; however, all of this growth did not occur between Q1 and Q3 2015. Rather, some of the growth is a result of updates received immediately following the March 2015 publication of this report.

Although the majority of committed payers have live functionality, ePA rarely extends to all the plans supported by a pharmacy benefit manager (PBM) or to all medications at the time of launch. As a result, until full rollout occurs, prescribers either need to use an ePA solution plus paper forms, or as a preferred method, electronically complete all PA requests through a web portal with universal compatibility for all plans and all medications.

Auto-determination functionality is likely to have the largest influence on decreasing the administrative burden for payers and increasing adoption with providers. Currently, only one ePA vendor in the market has auto-determination functionality.

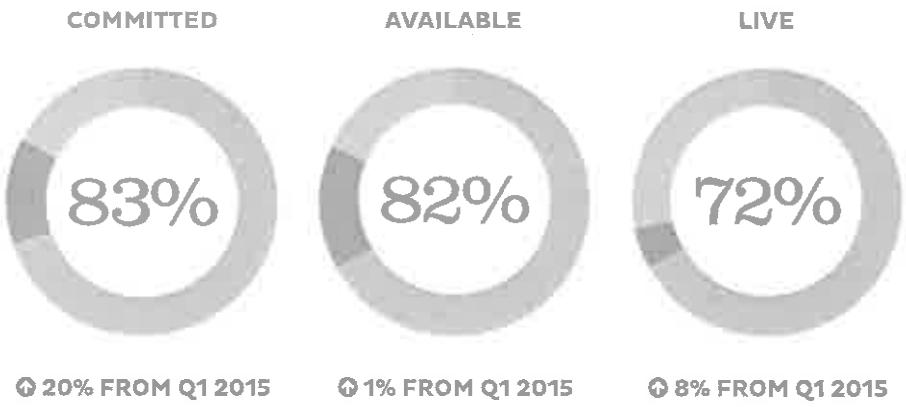
ePA Availability Status by Pharmacies

INTRODUCTION

The majority of PA requests are still initiated at the pharmacy, causing an administrative burden for pharmacists trying to fill prescriptions for their patients. According to CoverMyMeds, in 2014, 71% of PA requests were initiated at the pharmacy.

Integrating ePA functionality into pharmacy systems gives pharmacists the ability to create a PA, auto-fill patient and medication information, and electronically send it to the prescriber in one or two keystrokes. Electronic functionality significantly decreases administrative time for pharmacists, ensures more accurate data on the PA request, and prefills fields for the prescriber. The result is faster completion and submission to the payer.

Percentage of pharmacies committed to ePA and implementation status as of Q3 2015*



*Details companies representing the majority of market share.[11] This report may be updated with additional information provided by pharmacy vendors. Vendors can submit information to epascorecard@covermymeds.com.

PHARMACY	COMMITTED	AVAILABLE	LIVE
Ahold	●	●	●
Bi-Lo	●	●	●
Costco	●	●	●
CVS Specialty	●	●	●
CVS/pharmacy (Retail)	○	○	○
Good Neighbor Pharmacy Updated	●	●	○
H-E-B Updated	●	○	○
Health Mart (McKesson) Updated	●	●	●
Kmart Updated	●	●	○
Kroger	●	●	●
Medicine Shoppe International	●	●	●
Publix	●	●	●
RiteAid	●	●	●
Safeway/Albertsons	●	●	●
Target	●	●	●
Walgreens	●	●	●
Walmart	●	●	●

KEY

Committed = The company publicly announced they are committed to implementing an ePA solution.
Available = The company and the ePA vendor completed the integration work required for the ePA solution.
Live = The ePA solution is operational in a production environment.

11 - Drug Store News
12 - Drug Channels
2 - CoverMyMeds Data

PHARMACY SYSTEM VENDORS

Smaller chain and independent pharmacies often purchase and use software from a third-party technology vendor rather than create their own platforms. The pharmacy system vendors integrate with ePA providers to bring ePA functionality to pharmacists at each retail location.

PHARMACY VENDOR	COMMITTED	AVAILABLE	LIVE
AbacusRx	●	●	●
AdvanceNet Health Solutions	●	●	●
Best Computer Systems	●	●	●
BMI	●	○	○
CarePoint	●	●	●
Cerner	○	○	○
ComputerRx	●	○	○
DATASCAN	●	●	●
FSI	●	●	○
HBS, Inc. (RxGENESYS & RxAXIS)	●	●	●
Key Centrix	●	●	○
Lagniappe Pharmacy Systems	○	○	○
Liberty Computer Service	●	●	●
McKesson (Pharmaserv)	●	●	●
McKesson (Pharmacy Rx)	●	○	○
McKesson (Enterprise)	○	○	○
Micro Merchant Systems	●	●	●
PDX (Classic & EPS)	●	●	●
Pioneer Rx	●	●	●
Prodigy Data Systems, Inc.	●	●	●
QS/1	●	●	●
RNA	●	○	○
Rx30	●	●	●
ScriptPro	○	○	○
Speed Script	●	●	●
SRS Pharmacy Systems	●	○	○
SuiteRx	●	●	●
SWI Softwriters, Inc.	●	●	●
VIP Computer Systems	●	●	●

Details status by known pharmacy vendors.[2] This report may be updated with additional information provided by pharmacy vendors. Vendors can submit information to epascorecard@covermymeds.com.

KEY TAKEAWAYS

83% of pharmacies representing the majority of market share are committed to implementing ePA.

CVS/pharmacy is the last major chain not yet committed to an ePA solution that sends PA requests electronically to the prescriber.

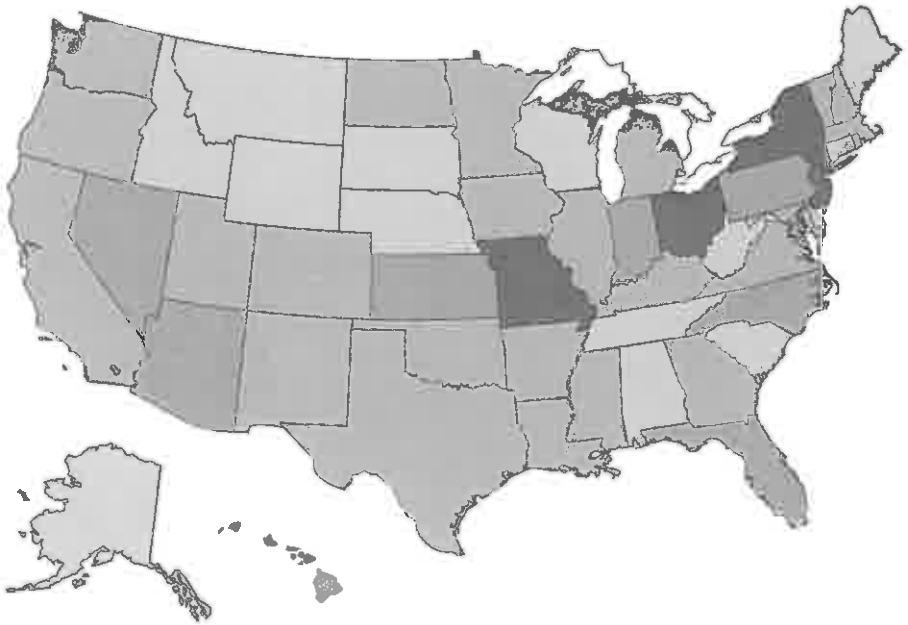
Many independent pharmacies have access to ePA functionality through pharmacy systems, most of which have live, integrated ePA capabilities.

ePA Legislation

INTRODUCTION

Prior authorization legislation has been in consideration—and in some cases in effect— since 2013. The intent of legislation is to make the PA submission process faster and easier for providers to prevent the delay of patient treatment. Unfortunately, with no federal direction, each state is on its own path. In many cases, that path leads to legislation that simply updates how paper forms are used or provides an option for electronic submission rather than legislates a mandate for true electronic prior authorization.

ePA LEGISLATION ACTIVITY BY STATE [13]



KEY

● = Active ● = Pending ● = Inactive or Dead ● = None

ACTIVE LEGISLATION

STATE	LAW	OVERVIEW
AR	AR Code § 23-99-420	Requires payers have a single form, not to exceed 2 pages, must accept electronic submissions.
CA	Cal. Health & Saf. Code § 1367.241 Cal. Ins. Code § 10123.191; Cal. Code Regs. Tit. 10 § 2218.30; Cal Code Regs. Tit. 28 § 1300.67.241 CA Senate Bill 282 (pending)	Requires the use of a universal form. SB 282 authorizes providers to use an electronic process meeting NCPDP SCRIPT Standard and require payers to accept electronic submissions.
CO	CRS § 10-16-124.5	Requires payers to allow electronic submission.
GA	GA Code Ann. § 33-64-8	Requires payers to support secure NCPDP EDI ePA transactions with prescribers. Prescribers are not required to use ePA.
IA	IA Code Ann. § 505.26	Proposed each payer create a standard form. The legislation is pending rules.
IL	215 ILCS 5/155.36 215 ILCS § 134/45.1	Establishes turnaround times for paper PA forms and ePA submissions.
KY	KRS Ann. § 217.211	Requires KY entities to consider E-Prescribing and ePA standards when implementing HIT improvements.
LA	LRS Ann. § 22:1006.1 LAC Tit. 50:1.3303 & 3503	Requires payers to use a single form, not exceeding 2 pages, and make it accessible via multiple operating systems.
MA	MGL C. 1760, § 25	Requires standard PA forms be used by payers and providers. Payers must make the form available electronically and accept electronic submissions.
MD	MD Code Ann. § 19-101 MD Code Ann. 19-108.2 COMAR 10.25.17.01-.06	Requires payers to be able to receive ePA transactions by 7/1/13. Providers must use ePA by 7/1/15.
MI	MI Comp. Laws § 500.2212c	Requires a workgroup to develop an ePA process by 1/1/15 and implement the process by 1/1/16.
MN	MN Stat. § 62J.497, Subdivision 5	Requires the use of a universal form. The use of NCPDP ePA transactions is required by 1/1/16. A new bill (SB 934) requires providers and payers using paper forms to use a universal form.

ACTIVE LEGISLATION (CONT.)

STATE	LAW	OVERVIEW
MS	MS Code Ann. § 83-9-6.3	Requires payers to have a single form, not to exceed 2 pages. Must allow for electronic submission.
NH	NH RSA § 420-J: 7-b, II	Requires a 48-hour turnaround for PA submissions.
ND	ND Cent. Code § 23-01-38	Requires ePA to be accessible in E-Prescribing systems and requires payers to accept ePA transactions.
NM	NM Stat. § 59A-2-9.8	Requires a universal PA form for all payers by 1/1/14. By 7/19/15 payers must accept electronic submissions from providers.
OK	OK Stat. Tit. 63 § 313	Requires payers to use a form not to exceed 3 pages. Payers may customize content by medication.
OR	OR Rev. Stat. § 743.801 OR Admin. R. 836-053-1205	Requires payers to accept a universal form, does not require rejection of non-universal forms. Payers are required to accept submissions sent electronically.
TX	TX Ins. Code § 1369.251-256 28 TX Admin. Code § 19.1820	Requires providers and payers to use a universal form by 9/1/15. ePA required 24 months after a national standard is named.
UT	UT HB 323	Requires a study of national standards and ePA adoption by 11/1/14. No report is available.
VA	VA Code Ann. § 38.2-3407.15	Requires payers to accept phone, fax or ePA submissions utilizing the NCPCP SCRIPT Standard.
WA	SB 231 created statute 22:1006:1, rules LAC 50:1.3303 and 3503	Requires carriers and pharmacy benefit managers to provide a listing of prior authorization requirements electronically on a web site.

PENDING LEGISLATION

STATE	LAW	OVERVIEW
NJ	2014 A 1713	Would require the use of a universal PA form.
NY	NYS SB 4721 NYS SB 604 NY A 1165	NYS SB 4721 indicates standards will be developed for PA requests considering the NCPDP SCRIPT Standard. S 604/NY A 1165 requires E-Prescribing systems to request and receive approval for PA submissions via a standard method TBD by the Board of Pharmacy.
OH	2015 SB 129	Requires payers have a single form, not to exceed 2 pages, must accept electronic submissions.
MO	2012 MO H1563 2014 HB 2186	Requires a pilot committee to recommend rules for the implementation of the NCPDP SCRIPT Standard once the standard is adopted. The pilot activated 1/1/2014, the final report is due in 2019.

INACTIVE OR DEAD LEGISLATION

STATE	LAW	OVERVIEW
AZ	SB 1361 (51st session, 2014)	Required payers to have a standard PA form available electronically and required the acceptance of electronic submissions.
FL	2014 SB 1354	Required a universal form for each payer and electronic submission.
HI	2012 HI 2436	Required a working group to consider ePA.
IN	2014 HB 1357	Required the development of a universal form and a two-day turnaround.
KS	2012 SB 134	Authorized a study and pilot of ePA but did not fund.
NV	2011 NV SB 43	Authorized an ePA study but the report was not completed.
NC	2012 HB 950	Authorized a study to determine feasibility of using the NCPDP SCRIPT Standard for Medicaid. No report is available.
PA	2013 H 1287	Required an ePA process 120 days after legislation passed for Medicaid only.
RI	2013 H 5590	Required a 48-hour turnaround for nonurgent submissions, and a two-hour turnaround for urgent submissions. The legislation is on hold.
VT	VT HB 559	Requires a standard form and ePA. Vermont abandoned ePA mandate for prescription drugs citing complexity issues.

NO LEGISLATION

Alabama, Alaska, Connecticut, Delaware, Idaho, Maine, Montana, Nebraska, South Carolina, South Dakota, Tenessee, West Virginia, Wisconsin, Wyoming

13 - Point-of-Care Partners ePriorAuth Navigator

covermymeds

KEY TAKEAWAYS

23 states have a law pertaining to prior authorization. Although several states allow for the use of ePA transactions according to the NCPDP SCRIPT Standard, only two states require payers to implement this standard for accepting ePA requests.

An equal number of states have either no ePA legislation or legislation that is dead or inactive.

Four states—Missouri, New Jersey, New York and Ohio—have pending legislation, two of which recommend the use or consideration of the NCPDP SCRIPT Standard.

Key Success Factors

ePA vendors can help drive adoption by providing open platforms and aligning on standards for transactions. The following are key success factors for vendors, and functionality industry participants should look for in a solution to optimize the value of an ePA process.

Plan Compatibility
ePA solutions will see greatest adoption when they are a "one-stop shop" to allow PA requests to be submitted to any plan. Early participants have found prescriber adoption is dependent on the ePA process becoming a consistent workflow for handling all prescriptions—not just those for a few payers.

Prospective PA
Prospective PA allows the prior authorization to be completed before a claim rejection occurs in the pharmacy, thereby saving time and disruption to the patient. To enable this, the prior authorization process must be initiated in the E-Prescribing workflow. With proper implementation, and combined with real-time auto-determination from the payer, the prior authorization process begins to look more like decision support for electronic prescribing.

Key Success Factors

☑ Retrospective PA

The majority of PA requests still occur after a claim rejection in the pharmacy. Over time, the prior authorization process will move to the point of prescribing, but only as formulary data challenges are resolved so that prescribers can adopt the prospective workflow. This process is likely to take many years. In the meantime, ePA vendors need to provide the ability to connect pharmacy-initiated PA requests into the prescriber workflow within the EHR system.

☑ Auto-Determination

Auto-determination functionality enables payers to set criteria for PA approvals and determinations to eliminate manual review. The result is a more efficient process for payers and faster determinations for prescribers. ePA vendors who offer this functionality should allow full customization of the criteria used to make an auto-determination.

☑ Financial Model

The market stands to save billions of dollars when prescribers adopt ePA solutions at scale. Financial models that encourage ubiquity are therefore in everyone's interest, and a good way to do that is to provide ePA solutions that do not charge prescribers.

☑ Open API

Open APIs make it easier for technology teams at EHR, payer and pharmacy systems to quickly implement ePA solutions. Documented, standards-based ePA APIs will be a key to driving adoption in the market.

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