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SENATE BILL NO. 1215

Offered January 8, 2025

Prefiled January 8, 2025

A BILL to amend and reenact § 38.2-3407.15:2 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.15:8, relating to health insurance; carrier contracts; required provisions regarding prior authorization for health care services; work group; report.

Patron—Pekarsky

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3407.15:2 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3407.15:8 as follows:

§ 38.2-3407.15:2. Carrier contracts; required provisions regarding prior authorization for drug benefits.

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

"Carrier" has the same meaning ascribed thereto as provided 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 as provided 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 such request.

B. Any provider contract between a carrier and a participating health care provider with prescriptive authority, 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, including weekend 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 a prior authorization request is approved for prescription drugs and such prescription drugs have been scheduled, provided, or delivered to the patient consistent with the authorization, the carrier shall not revoke, limit, condition, modify, or restrict that authorization unless (i) there is evidence that the authorization was obtained based on fraud or misrepresentation; (ii) final actions by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer remove the drug from the market, limit its use in a manner that affects the authorization, or communicate a patient safety issue that would affect the authorization alone or in combination with other authorizations; (iii) a combination of drugs prescribed would cause a drug interaction; or (iv) a generic or biosimilar is added to the prescription drug formulary. Nothing in this section shall require a carrier to cover any benefit not otherwise covered or cover a prescription drug if the enrollee is no longer covered by a health plan on the date the prescription drug was scheduled, provided, or delivered;

6. 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;

7. Require that prior authorization approved by another carrier be honored, upon the carrier's receipt from the prescriber or his designee of a record demonstrating the previous carrier's prior authorization approval or any written or electronic evidence of the previous carrier's coverage of such drug, at least for the initial 90 days of a member's prescription drug benefit coverage under a new health plan, subject to the provisions of the new carrier's evidence of coverage and any exception listed in subdivision 5;

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59 8. Require that a tracking system be used by the carrier for all prior authorization requests and that the
60 identification information be provided electronically, telephonically, or by facsimile to the prescriber or his
61 designee, upon the carrier's response to the prior authorization request;

62 9. Require that the carrier's prescription drug formularies, all drug benefits subject to prior authorization
63 by the carrier, all of the carrier's prior authorization procedures, and all prior authorization request forms
64 accepted by the carrier be made available through one central location on the carrier's website and that such
65 information be updated by the carrier within seven days of approved changes;

66 10. Require a carrier to honor a prior authorization issued by the carrier for a drug, other than an opioid,
67 regardless of changes in dosages of such drug, provided such drug is prescribed consistent with U.S. Food
68 and Drug Administration-labeled dosages;

69 11. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless of whether
70 the covered person changes plans with the same carrier and the drug is a covered benefit with the current
71 health plan;

72 12. Require a carrier, when requiring a prescriber to provide supplemental information that is in the
73 covered individual's health record or electronic health record, to identify the specific information required;

74 13. Require that no prior authorization be required for at least one drug prescribed for substance abuse
75 medication-assisted treatment, provided that (i) the drug is a covered benefit, (ii) the prescription does not
76 exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board
77 of Medicine;

78 14. Require that when any carrier has previously approved prior authorization for any drug prescribed for
79 the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of
80 Mental Disorders published by the American Psychiatric Association, no additional prior authorization shall
81 be required by the carrier, provided that (i) the drug is a covered benefit; (ii) the prescription does not exceed
82 the FDA-labeled dosages; (iii) the prescription has been continuously issued for no fewer than three months;
83 and (iv) the prescriber performs an annual review of the patient to evaluate the drug's continued efficacy,
84 changes in the patient's health status, and potential contraindications. Nothing in this subdivision shall
85 prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug
86 formulary at the time the initial prescription for the drug is issued;

87 15. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless of whether
88 the drug is removed from the carrier's prescription drug formulary after the initial prescription for that drug is
89 issued, provided that the drug and prescription are consistent with the applicable provisions of subdivision
90 14;

91 16. Require a carrier, beginning July 1, 2025, notwithstanding the provisions of subdivision 1 or any other
92 provision of this section, to establish and maintain an online process that (i) links directly to all e-prescribing
93 systems and electronic health record systems that utilize the National Council for Prescription Drug Programs
94 SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard; (ii)
95 can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior
96 authorization requests (a) for which no additional information is needed by the carrier to process the prior
97 authorization request, (b) for which no clinical review is required, and (c) that meet the carrier's criteria for
98 approval; and (iv) links directly to real-time patient out-of-pocket costs for the office visit, considering
99 copayment and deductible, and (v) otherwise meets the requirements of this section. No carrier shall (a)
100 impose a fee or charge on any person for accessing the online process as required by this subdivision or (b)
101 access, absent provider consent, provider data via the online process other than for the enrollee. No later than
102 July 1, 2024, a carrier shall provide contact information of any third-party vendor or other entity the carrier
103 will use to meet the requirements of this subdivision or the requirements of § 38.2-3407.15:7 to any provider
104 that requests such information. A carrier that posts such contact information on its website shall be
105 considered to have met this requirement; and

106 17. Require a participating health care provider, beginning July 1, 2025, to ensure that any e-prescribing
107 system or electronic health record system owned by or contracted for the provider to maintain an enrollee's
108 health record has the ability to access, at the point of prescribing, the electronic prior authorization process
109 established by a carrier as required by subdivision 16 and the real-time patient-specific benefit information,
110 including out-of-pocket costs and more affordable medication alternatives made available by a carrier
111 pursuant to § 38.2-3407.15:7. A provider may request a waiver of compliance under this subdivision for
112 undue hardship for a period specified by the appropriate regulatory authority with the Health and Human
113 Resources Secretariat.

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

116 D. This section shall apply with respect to any contract between a carrier and a participating health care
117 provider; or its contracting agent; that is entered into, amended, extended, or renewed on or after January 1,
118 2016.

119 E. Notwithstanding any law to the contrary, the provisions of this section shall not apply to:

120 1. Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

121 (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the
122 Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10
123 U.S.C. § 1071 et seq. (TRICARE);

124 2. Accident only, credit or disability insurance, long-term care insurance, TRICARE supplement,
125 Medicare supplement, or workers' compensation coverages;

126 3. Any dental services plan or optometric services plan as defined in § 38.2-4501; or

127 4. Any health maintenance organization that (i) contracts with one multispecialty group of physicians who
128 are employed by and are shareholders of the multispecialty group, which multispecialty group of physicians
129 may also contract with health care providers in the community; (ii) provides and arranges for the provision of
130 physician services by such multispecialty group physicians or by such contracted health care providers in the
131 community; and (iii) receives and processes at least 85 percent of prescription drug prior authorization
132 requests in a manner that is interoperable with e-prescribing systems, electronic health records, and health
133 information exchange platforms.

134 **§ 38.2-3407.15:8. Carrier contracts; required provisions regarding prior authorization for health care**
135 **services.**

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

137 "Carrier" has the same meaning as provided in subsection A of § 38.2-3407.15.

138 "Expedited" means, in relation to a health care service or a prior authorization request for a health care
139 service, that the delay of such service could jeopardize the life, health, or functionality of the enrollee, as
140 determined by the provider.

141 "Health care services" has the same meaning as provided in § 38.2-3407.15, except that as used in this
142 section, "health care services" does not include drug benefits for which prior authorization is required.

143 "Prior authorization" means the approval process used by a carrier before certain health care services
144 may be provided.

145 "Provider" has the same meaning as provided in § 38.2-3407.10.

146 "Provider contract" has the same meaning as provided in subsection A of § 38.2-3407.15.

147 "Standard" means, in relation to a health care service or a prior authorization request for a health care
148 service, that such health care service or prior authorization request is not expedited.

149 "Supplementation" means a request communicated by the carrier to the provider or his designee for
150 additional information, limited to items specifically requested on the applicable prior authorization request,
151 necessary to approve or deny such request.

152 B. Any provider contract between a carrier and a participating health care provider or its contracting
153 agent shall contain specific provisions that:

154 1. Require that the carrier communicate electronically or telephonically to the provider or his designee
155 within 72 hours, including weekend hours, of submission of an expedited prior authorization request to the
156 carrier that the request is approved, denied, or requires supplementation;

157 2. Require that the carrier communicate electronically or telephonically to the provider or his designee
158 within seven calendar days of submission of a fully completed prior authorization request to the carrier that
159 the request is approved, denied, or requires supplementation;

160 3. Require that the carrier communicate electronically or telephonically to the provider or his designee (i)
161 within seven calendar days of submission of a properly completed supplementation from the provider or his
162 designee to the carrier that the request is approved or denied or (ii) within 72 hours, including weekend
163 hours, of submission of a properly completed supplementation from the provider or his designee to the
164 carrier for an expedited prior authorization request that the request is approved or denied;

165 4. Require that if a prior authorization request is approved for health care services and such health care
166 services have been scheduled, provided, or delivered to the enrollee consistent with the authorization, the
167 carrier shall not revoke, limit, condition, modify, or restrict that authorization unless (i) there is evidence that
168 the authorization was obtained based on fraud or misrepresentation or (ii) a final action by a federal
169 regulatory agency or the manufacturer removes an approved health care service from the market, limits its
170 use in a manner impacting the prior authorization, or communicates a patient safety issue that would impact
171 the prior authorization. Nothing in this section shall require a carrier to authorize any health care service if
172 the enrollee is no longer enrolled in the health plan; and

173 5. Require that if the prior authorization request is denied, the carrier shall communicate electronically
174 or telephonically to the provider or his designee within the timeframes established by subdivision 1, 2, or 3,
175 as applicable, the reasons for the denial.

176 C. A carrier shall make a list of health care services and codes for which prior authorization is required
177 publicly available in one central location on such carrier's website, including services for which prior
178 authorization is performed by an entity under contract with the carrier. The website shall include all prior
179 authorization request forms accepted by the carrier. For each service for which prior authorization is
180 required, the website shall indicate (i) the date on which the carrier begins requiring prior authorization for
181 such service; (ii) the date on which such requirement is listed on the website; and (iii) where applicable, the

182 *date on which the carrier ends such requirement. If prior authorization for a health care service was*
183 *required on or prior to January 1, 2027, the carrier shall indicate an effective date of January 1, 2027.*

184 *D. A carrier shall post any change or update to the information required by subsection C to the carrier's*
185 *website at least 30 calendar days before the effective date of such change or update. No provision of this*
186 *section shall prevent a carrier from removing a prior authorization requirement without the required 30-day*
187 *notice period in the event of a pandemic, natural disaster, or other emergency situation.*

188 *E. No carrier shall deny a claim for failure to obtain prior authorization if the prior authorization*
189 *requirement for such service was not posted to the carrier's website in accordance with subsections C and D.*

190 *F. On or before March 31 of each year, a carrier shall post the following data from the previous calendar*
191 *year on such carrier's website:*

192 *1. The percentage of standard prior authorization requests that were approved;*

193 *2. The percentage of standard prior authorization requests that were denied;*

194 *3. The percentage of standard prior authorization requests that were approved after supplementation;*

195 *4. The percentage of expedited prior authorization requests that were approved;*

196 *5. The percentage of expedited prior authorization requests that were denied;*

197 *6. The percentage of expedited prior authorization requests that were approved after supplementation;*

198 *7. The percentage of prior authorization requests for which the timeframe for review was extended and*
199 *that were subsequently approved;*

200 *8. The average and median time elapsed between the submission of a standard prior authorization request*
201 *and the communication of the carrier's decision to the provider or his designee;*

202 *9. The average and median time elapsed between the submission of an expedited prior authorization*
203 *request and the communication of the carrier's decision to the provider or his designee; and*

204 *10. The percentage of all paid claims that were subject to prior authorization requirements, both in the*
205 *aggregate and separated by expedited and standard request classification.*

206 *G. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this*
207 *section.*

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

210 **2. That the provisions of the first enactment this act shall become effective on January 1, 2027, and**
211 **shall apply only with respect to provider contracts entered into, amended, extended, or renewed on or**
212 **after January 1, 2026.**

213 **3. That the State Corporation Commission's Bureau of Insurance shall establish, in coordination with**
214 **the Secretary of Health and Human Resources, a work group to (i) monitor anticipated federal**
215 **developments related to the implementation of requirements to make publicly available information**
216 **pertaining to prior authorization for health care services consistent with the provisions of §**
217 **38.2-3407.15:8 of the Code of Virginia, as created by this act; (ii) assess industry progress and**
218 **readiness to implement such requirements; and (iii) evaluate policies supporting the effective and**
219 **efficient adoption of such requirements. The work group shall include relevant stakeholders, including**
220 **representatives from the Virginia Association of Health Plans, the Virginia Hospital and Healthcare**
221 **Association, the Medical Society of Virginia, and other parties with an interest in the implementation**
222 **of transparency requirements for information pertaining to prior authorization for health care**
223 **services. The work group shall report its findings and recommendations to the Chairs of the Senate**
224 **Committees on Commerce and Labor and Education and Health and the House Committees on Labor**
225 **and Commerce and Health and Human Services on or before November 1, 2025.**