

1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

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

5 [S 1215]

6 Approved

7 **Be it enacted by the General Assembly of Virginia:**

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

10 **§ 38.2-3407.15:2. Carrier contracts; required provisions regarding prior authorization for drug**
 11 **benefits.**

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

13 "Carrier" has the same meaning ~~ascribed thereto~~ *as provided* in subsection A of § 38.2-3407.15.

14 "Prior authorization" means the approval process used by a carrier before certain drug benefits may be
 15 provided.

16 "Provider contract" has the same meaning ~~ascribed thereto~~ *as provided* in subsection A of § 38.2-3407.15.

17 "Supplementation" means a request communicated by the carrier to the prescriber or his designee, for
 18 additional information, limited to items specifically requested on the applicable prior authorization request,
 19 necessary to approve or deny a ~~prior authorization~~ *such* request.

20 B. Any provider contract between a carrier and a participating health care provider with prescriptive
 21 authority, or its contracting agent, shall contain specific provisions that:

22 1. Require the carrier to, in a method of its choosing, accept telephonic, facsimile, or electronic
 23 submission of prior authorization requests that are delivered from e-prescribing systems, electronic health
 24 record systems, and health information exchange platforms that utilize the National Council for Prescription
 25 Drug Programs' SCRIPT standards;

26 2. Require that the carrier communicate to the prescriber or his designee within 24 hours, including
 27 weekend hours, of submission of an urgent prior authorization request to the carrier, if submitted
 28 telephonically or in an alternate method directed by the carrier, that the request is approved, denied, or
 29 requires supplementation;

30 3. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or
 31 his designee, within two business days of submission of a fully completed prior authorization request, that the
 32 request is approved, denied, or requires supplementation;

33 4. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or
 34 his designee, within two business days of submission of a properly completed supplementation from the
 35 prescriber or his designee, that the request is approved or denied;

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

47 6. Require that if the prior authorization request is denied, the carrier shall communicate electronically,
 48 telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by
 49 subdivision 3 or 4, as applicable, the reasons for the denial;

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

55 8. Require that a tracking system be used by the carrier for all prior authorization requests and that the
 56 identification information be provided electronically, telephonically, or by facsimile to the prescriber or his

57 designee, upon the carrier's response to the prior authorization request;

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

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

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

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

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

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

83 15. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless of whether
84 the drug is removed from the carrier's prescription drug formulary after the initial prescription for that drug is
85 issued, provided that the drug and prescription are consistent with the applicable provisions of subdivision
86 14;

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

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

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

112 D. This section shall apply with respect to any contract between a carrier and a participating health care
113 provider; or its contracting agent; that is entered into, amended, extended, or renewed on or after January 1,
114 2016.

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

116 1. Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.
117 (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the

118 Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10
 119 U.S.C. § 1071 et seq. (TRICARE);

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

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

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

130 **§ 38.2-3407.15:8. Carrier contracts; required provisions regarding prior authorization for health care**
 131 **services.**

132 A. As used in this section:

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

134 "Expedited" means, in relation to a health care service or a prior authorization request for a health care
 135 service, that the delay of such service could seriously jeopardize the enrollee's life, health, or ability to regain
 136 maximum function.

137 "Health care services" has the same meaning as provided in § 38.2-3407.15, except that as used in this
 138 section, "health care services" does not include drugs that are subject to the requirements of § 38.2-3407.15:

139 2.

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

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

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

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

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

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

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

154 2. Require that the carrier communicate electronically or telephonically to the provider or his designee
 155 within seven calendar days of submission of a standard prior authorization request to the carrier that the
 156 request is approved, denied, or requires supplementation;

157 3. Where supplementation is required, require the carrier to specify to the provider or his designee the
 158 supplementation necessary for the carrier to make a final determination that the request is approved or denie
 159 d, and following properly completed supplementation from the provider or his designee, require the carrier
 160 to approve or deny the request within the timeframes specified in subdivisions 1 and 2;

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

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

172 C. If a carrier requires prior authorization for certain health care services to be covered, the carrier shall
 173 make available through one central location on the carrier's publicly accessible website or other electronic
 174 application the list of services and codes for which prior authorization is required. A carrier must notify
 175 providers at least 30 calendar days in advance of the effective date of any changes to the list of prior
 176 authorization requirements and update the publicly accessible list of services and codes for which prior
 177 authorization is required by the effective date of any new requirement. All of the carrier's prior authorization
 178 procedures and all prior authorization request forms accepted by the carrier shall also be made available

179 and updated by the carrier on the publicly accessible website or other electronic application by the effective
180 date of any new requirements. The carrier shall also indicate the effective date of the prior authorization
181 requirements for each service on the list, including those services where prior authorization is performed by
182 an entity under contract with the carrier, provided, however, that if the prior authorization was already
183 required prior to January 1, 2027, the carrier may indicate an effective date of January 1, 2027.

184 D. A carrier shall not deny a claim for failure to obtain prior authorization if the prior authorization
185 requirements for the date of service were not posted on the publicly accessible website or other electronic
186 application in accordance with subsection C.

187 E. Nothing in this section shall prohibit a carrier from removing prior authorization requirements without
188 the 30-day notice period to providers in the event of a pandemic, a natural disaster, or any other emergency
189 situations.

190 F. Each carrier shall make available by posting on its website no later than March 31 of each year the
191 prior authorization data for prior authorizations covered by this section for the previous calendar year at the
192 health plan level for all metrics required for compliance with federal law and the regulations of the Centers
193 for Medicare and Medicaid Services, including those promulgated under 42 C.F.R. §§ 422.122(c),
194 438.210(f), 440.230(e)(3), and 457.732(c).

195 G. Notwithstanding any law to the contrary, no provision of this section shall apply to any health
196 maintenance organization that (i) contracts with a multispecialty group of physicians who are employed by
197 and are shareholders of such multispecialty group, which multispecialty group may also contract with health
198 care providers in the community; and (ii) provides and arranges for the provision of physician services by the
199 physician members of such multispecialty group or by such contracted health care providers.

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

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

204 **2. That the provisions of the first enactment this act shall become effective on January 1, 2027.**

205 **3. That the State Corporation Commission's Bureau of Insurance shall establish, in coordination with**
206 **the Secretary of Health and Human Resources, a work group to (i) monitor anticipated federal**
207 **developments related to the implementation of requirements to make publicly available information**
208 **pertaining to prior authorization for health care services consistent with the provisions of §**
209 **38.2-3407.15:8 of the Code of Virginia, as created by this act; (ii) assess industry progress and**
210 **readiness to implement such requirements; and (iii) evaluate policies supporting the effective and**
211 **efficient adoption of such requirements. The work group shall include relevant stakeholders, including**
212 **representatives from the Virginia Association of Health Plans, the Virginia Hospital and Healthcare**
213 **Association, the Medical Society of Virginia, and other parties with an interest in the implementation**
214 **of transparency requirements for information pertaining to prior authorization for health care**
215 **services. The work group shall report its findings and recommendations to the Chairs of the Senate**
216 **Committees on Commerce and Labor and Education and Health and the House Committees on Labor**
217 **and Commerce and Health and Human Services on or before November 1, 2025.**