CHAPTER 284

An Act to amend and reenact § 38.2-3407.15:2 of the Code of Virginia and the second enactment of Chapters 474 and 475 of the Acts of Assembly of 2023, relating to health insurance; electronic prior authorization; work group; report.

[H 2525]

Approved March 21, 2025

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 as follows:

§ 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 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;

8. 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;

9. 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;

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

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

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

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

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

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

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

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

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

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

4. 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.

2. That the second enactment of Chapters 474 and 475 of the Acts of Assembly of 2023 is amended and reenacted as follows:

2. That the State Corporation Commission's Bureau of Insurance (the Bureau) shall, in coordination with the Secretary of Health and Human Resources, establish a work group to (i) ~~assess progress toward implementing electronic prior authorization and real-time cost benefit information for prescription drugs, as required by this act, including monitoring and evaluating the impact of any state or federal developments; (ii) evaluate and make recommendations to establish a process for electronic prior authorization for surgery and other procedures in order to maximize efficiency and minimize delays; (iii) evaluate and make recommendations to establish an online process for a real-time link at the point of prescribing for any available prescription coupons, and (iv) make recommendations for any additional statutory changes required to facilitate such implementation or to establish such processes~~ *monitor anticipated federal developments related to the implementation of electronic prior authorization for medical items and services, (ii) assess industry progress and readiness to implement electronic prior authorization for medical items and services, and (iii) evaluate policies supporting the effective and efficient adoption of electronic prior authorization for medical items and services.* The work group shall include relevant stakeholders, including representatives from the Virginia Association of Health Plans, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Pharmacists Association, and other parties with an interest in the underlying technology. The work group shall report its findings and recommendations to the Chairmen of the Senate Committees on Commerce and Labor and Education and Health and the House Committees on ~~Commerce and Energy~~ *Labor and Commerce* and Health~~, Welfare and Institutions~~ *and Human Services* annually by November 1 and shall make its final report by November 1, ~~2025~~ *2028. In its November 1, 2025 report, the work group shall provide a final assessment of progress toward implementing electronic prior authorization and real-time cost benefit information for prescription drugs in the Commonwealth and shall recommend a date by which health carriers and providers shall implement electronic prior authorization for medical items and services.*