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SENATE BILL NO. 476

Offered January 14, 2026

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A BILL to amend and reenact §§ 38.2-3407.15:2 and 38.2-3407.15:8, as they shall become effective, of the Code of Virginia, relating to health insurance; prior authorization requests reviewed by physician.

Patron—DeSteph

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3407.15:2 and 38.2-3407.15:8, as they shall become effective, of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3407.15:2. (Effective January 1, 2027) 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 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 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 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 (i) any decision to deny a prior authorization request is made by a licensed physician who is (a) an expert in the treatment of enrollee's medical condition that is the subject of the prior authorization request and (b) knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the enrollee; (ii) if the carrier is questioning the medical necessity of the request, the carrier shall provide the enrollee's physician an opportunity to discuss the medical necessity of the health care service with the physician who will be responsible for determining authorization of the health care service under review; and (iii) 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

59 applicable, the reasons for the denial;

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

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

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

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

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

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

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

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

93 15. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless of whether
94 the drug is removed from the carrier's prescription drug formulary after the initial prescription for that drug is
95 issued, provided that the drug and prescription are consistent with the applicable provisions of subdivision
96 14;

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

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

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

121 section.

122 D. This section shall apply with respect to any contract between a carrier and a participating health care
123 provider or its contracting agent that is entered into, amended, extended, or renewed on or after January 1,
124 2016.

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

126 1. Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.
127 (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the
128 Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10
129 U.S.C. § 1071 et seq. (TRICARE);

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

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

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

140 **§ 38.2-3407.15:8. (Effective January 1, 2027) Carrier contracts; required provisions regarding prior**
141 **authorization for health care services.**

142 A. As used in this section:

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

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

147 "Health care services" has the same meaning as provided in § 38.2-3407.15, except that as used in this
148 section, "health care services" does not include drugs that are subject to the requirements of § 38.2-3407.15:2.

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

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

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

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

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

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

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

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

166 3. Where supplementation is required, require the carrier to specify to the provider or his designee the
167 supplementation necessary for the carrier to make a final determination that the request is approved or denied,
168 and following properly completed supplementation from the provider or his designee, require the carrier to
169 approve or deny the request within the timeframes specified in subdivisions 1 and 2;

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

178 5. Require that (i) any decision to deny a prior authorization request is made by a licensed physician who
179 is (a) an expert in the treatment of enrollee's medical condition that is the subject of the prior authorization
180 request and (b) knowledgeable about the recommended health care service or treatment through recent or
181 current actual clinical experience treating patients with the same or similar medical condition of the
182 enrollee; (ii) if the carrier is questioning the medical necessity of the request, the carrier shall provide the

183 *enrollee's physician an opportunity to discuss the medical necessity of the health care service with the*
184 *physician who will be responsible for determining authorization of the health care service under review; and*
185 *(iii) if the prior authorization request is denied, the carrier shall communicate electronically or telephonically*
186 *to the provider or his designee within the timeframes established by subdivision 1 or 2, as applicable, the*
187 *reasons for the denial.*

188 C. If a carrier requires prior authorization for certain health care services to be covered, the carrier shall
189 make available through one central location on the carrier's publicly accessible website or other electronic
190 application the list of services and codes for which prior authorization is required. A carrier must notify
191 providers at least 30 calendar days in advance of the effective date of any changes to the list of prior
192 authorization requirements and update the publicly accessible list of services and codes for which prior
193 authorization is required by the effective date of any new requirement. All of the carrier's prior authorization
194 procedures and all prior authorization request forms accepted by the carrier shall also be made available and
195 updated by the carrier on the publicly accessible website or other electronic application by the effective date
196 of any new requirements. The carrier shall also indicate the effective date of the prior authorization
197 requirements for each service on the list, including those services where prior authorization is performed by
198 an entity under contract with the carrier, provided, however, that if the prior authorization was already
199 required prior to January 1, 2027, the carrier may indicate an effective date of January 1, 2027.

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

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

206 F. Each carrier shall make available by posting on its website no later than March 31 of each year the
207 prior authorization data for prior authorizations covered by this section for the previous calendar year at the
208 health plan level for all metrics required for compliance with federal law and the regulations of the Centers
209 for Medicare and Medicaid Services, including those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f),
210 440.230(e)(3), and 457.732(c).

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

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

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