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SENATE BILL NO. 500

Offered January 14, 2026

Prefiled January 13, 2026

A BILL to amend and reenact §§ 38.2-3407.15:8, as it shall become effective, and 38.2-4509 of the Code of Virginia, relating to health insurance; prior authorization for health care services.

Patron—DeSteph

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3407.15:8, as it shall become effective, and 38.2-4509 of the Code of Virginia are amended and reenacted as follows:

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

A. As used in this section:

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

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

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

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

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

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

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

"Supplementation" means a request communicated by the carrier to the provider 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 or its contracting agent shall contain specific provisions that:

1. Require that the carrier communicate electronically or telephonically to the provider or his designee within ~~72~~ 24 hours, including weekend hours, of submission of an expedited prior authorization request to the carrier that the request is approved, denied, or requires supplementation;

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

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

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

5. Require that if the prior authorization request is denied, the carrier shall communicate electronically or telephonically to the provider or his designee within the timeframes established by subdivision 1 or 2, as applicable, the reasons for the denial *and if any artificial intelligence-based tool, as defined in § 19.2-11.14, was used in reviewing the request;*

6. *Require that if a prior authorization request is approved for health care services, the carrier shall not downcode the resulting claim; and*

7. *Require that the carrier establish a system in which providers with high prior authorization approval rates are not required to obtain prior authorization for routine health care services.*

59 C. If a carrier requires prior authorization for certain health care services to be covered, the carrier shall
 60 make available through one central location on the carrier's publicly accessible website or other electronic
 61 application the list of services and codes for which prior authorization is required. A carrier must notify
 62 providers at least 30 calendar days in advance of the effective date of any changes to the list of prior
 63 authorization requirements and update the publicly accessible list of services and codes for which prior
 64 authorization is required by the effective date of any new requirement. All of the carrier's prior authorization
 65 procedures and all prior authorization request forms accepted by the carrier shall also be made available and
 66 updated by the carrier on the publicly accessible website or other electronic application by the effective date
 67 of any new requirements. The carrier shall also indicate the effective date of the prior authorization
 68 requirements for each service on the list, including those services where prior authorization is performed by
 69 an entity under contract with the carrier, provided, however, that if the prior authorization was already
 70 required prior to January 1, 2027, the carrier may indicate an effective date of January 1, 2027.

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

74 E. *No carrier shall deny a claim for the provision of dental services by a dentist or oral surgeon for
 75 failure to obtain prior authorization if the dentist or oral surgeon calls the dental plan during business hours
 76 to obtain such prior authorization and is unable to reach the dental plan or is placed on hold for longer than
 77 15 minutes. For the purposes of this subsection, "carrier" includes any "dental plan" as defined in §
 78 38.2-3407.17.*

79 *F. If a carrier denies a request for prior authorization for health care services, the carrier shall notify the
 80 enrollee in writing the reasons for such denial in plain language and shall disclose the use of any artificial
 81 intelligence-based tools, as defined in § 19.2-11.14, used in reviewing the request.*

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

85 ~~F. H.~~ Each carrier shall make available by posting on its website no later than March 31 of each year the
 86 prior authorization data for prior authorizations covered by this section for the previous calendar year at the
 87 health plan level for all metrics required for compliance with federal law and the regulations of the Centers
 88 for Medicare and Medicaid Services, including those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f),
 89 440.230(e)(3), and 457.732(c).

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

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

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

99 **§ 38.2-4509. Application of certain laws.**

100 A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter,
 101 §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316,
 102 38.2-316.2, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600
 103 through 38.2-629, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1
 104 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1,
 105 Articles 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 6 (§ 38.2-1335 et seq.) of Chapter 13,
 106 §§ 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404,
 107 38.2-3405, 38.2-3407.1, 38.2-3407.4, 38.2-3407.10, 38.2-3407.10:1, 38.2-3407.13, 38.2-3407.14,
 108 38.2-3407.15, *subsection E of § 38.2-3407.15:8*, 38.2-3407.17, 38.2-3407.17:1, 38.2-3407.19, 38.2-3415,
 109 38.2-3541, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603, Chapter 55
 110 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and Chapter 65 (§ 38.2-6500 et seq.) shall apply to
 111 the operation of a plan.

112 B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The provisions
 113 of subsection C of § 38.2-322 shall apply to a dental services plan.

114 C. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not apply to either
 115 an optometric or dental services plan.

116 D. The provisions of § 38.2-3407.1 shall apply to claim payments made on or after January 1, 2014. No
 117 optometric or dental services plan shall be required to pay interest computed under § 38.2-3407.1 if the total
 118 interest is less than \$5.

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