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SENATE BILL NO. 586

Offered January 14, 2026

Prefiled January 14, 2026

A BILL to amend and reenact §§ 38.2-3407.15 and 38.2-3556 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3570.1, relating to use of artificial intelligence; right to expedited appeal; civil penalties.

Patron—Salim

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3407.15 and 38.2-3556 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3570.1 as follows:

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Artificial intelligence" or "AI" means a machine-based system that undertakes analysis, reasoning, and problem solving, and that can be used to generate predictions, recommendations, or other content.

"Carrier," "enrollee," and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim that does all of the following:

1. Identifies the provider that provided the service with industry-standard identification criteria, including billing and rendering provider names, identification numbers, and address;

2. Identifies the patient with a carrier-assigned identification number so the carrier can verify the patient was an enrollee at the time of service;

3. Identifies the service rendered using an industry-standard system of procedure or service coding, or, if applicable, a methodology required under the provider contract. The claim shall include a complete listing of all relevant diagnoses, procedures, and service codes, as well as any applicable modifiers;

4. Specifies the date and place of service;

5. If prior authorization is required for the services listed in the claim, contains verification that prior authorization was obtained in accordance with the provider contract for those services; and

6. Includes additional documentation specific to the services rendered as required by the carrier in its provider contract.

Notwithstanding the above criteria, a claim shall be considered a clean claim if a carrier has failed timely to notify the person submitting the claim of any defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) 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) or 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); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other

payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, notify the person submitting the claim of any defect or impropriety that prevents the carrier from deeming the claim a clean claim and request the information that will be required to process and pay the claim. Upon receipt of the additional information necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 8. Beginning no later than January 1, 2026, all notifications and information required under this subdivision shall be delivered electronically.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. A carrier shall notify the provider in the provider contract if the carrier, or entity completing a transaction on behalf of the carrier, uses a payment method that imposes a transaction or processing fee or similar charge on the provider, and shall offer the provider an alternative payment method in which the carrier, or entity completing a transaction on behalf of the carrier, does not impose such a fee or similar charge. If the provider elects to accept the alternative payment method and has provided all required information to the carrier to enroll in such alternative method, the carrier shall pay the claim using such alternative payment method.

5. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy

would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

6. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or

c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

7. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

8. No carrier shall impose any retroactive denial of a previously paid claim or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier has provided a written explanation of why the claim is being retroactively adjusted, and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed 12 months. Notwithstanding the provisions of clause (iii), a provider and a carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier shall notify a provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously paid claim.

Beginning no later than January 1, 2026, all written communications, explanations, notifications, and related provider responses applicable to this subdivision shall be delivered electronically. The electronic method and location for delivery shall be agreed upon by the carrier and provider and included in the provider contract.

9. No provider contract shall fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subdivision 5) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers. If a carrier's claim denial is overturned following completion of a dispute review, the carrier shall, on the day the decision to overturn is made, consider the claims impacted by such decision as clean claims. All applicable laws related to the payment of a clean claim shall apply to the payments due.

13. Every carrier shall include in its provider contracts a provision that prohibits a provider from

discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require a health care provider to treat an enrollee who has threatened to make or has made a professional liability claim against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.

14. Beginning July 1, 2025, every carrier shall make available through electronic means a way for providers to determine whether an enrollee is covered by a health plan that is subject to the Commission's jurisdiction.

15. All carriers shall (i) publicly disclose any use of AI to manage insurance claims and coverage, including in underlying algorithms, data used, and resulting determinations; (ii) submit to the Commission, upon request, all information, including documents and software, necessary for enforcement of this section; (iii) maintain documentation of AI decisions for at least five years; and (iv) provide notice to enrollees and health care providers when AI has been used to issue an adverse determination and provide a clear and timely process for appealing the determination.

C. A provider shall not file a complaint with the Commission for failure to pay claims in accordance with subdivision B 1 unless:

1. Such provider has made a reasonable effort to confer with the carrier in order to resolve the issues related to all claims that are under dispute. Any request to confer shall be made to the contact listed for such purpose in the provider contract and shall include supporting documentation sufficient for the carrier to identify the claims in question; and

2. At least 30 calendar days have passed from the date of the request provided that the carrier has been responsive to the provider's request to confer. However, if in the judgment of the provider, the carrier has not been responsive to such request, the provider shall not be required to wait at least 30 calendar days to file the complaint.

The provider shall attest in any such complaint that it has satisfied the provisions of this subsection.

D. If the Commission has cause to believe that any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why the actions in questions were not violations. If any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Board of Medicine or the Commissioner of Health may levy a fine or cost recovery upon the provider and take other action as permitted under its authority. Upon completion of its review of any potential violation submitted by the Commission or initiated directly by an enrollee, the Board of Medicine or the Commissioner of Health shall notify the Commission of the results of the review, including where the violation was substantiated, and any enforcement action taken as a result of a finding of a substantiated violation.

E. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

F. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

G. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

H. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

I. Except where otherwise provided in this section, beginning no later than July 1, 2025, carriers shall

deliver provider contracts, related amendments, and notices exclusively to providers in an electronic format other than electronic facsimile. Beginning no later than January 1, 2026, the provider shall submit provider contracts, amendments, and notices to carriers exclusively in an electronic format other than electronic facsimile. The electronic method and location for delivery shall be agreed upon by the carrier and provider and included in the provider contract.

J. This section shall apply only to carriers subject to regulation under this title and shall apply to the carrier and provider, regardless of any vendors, subcontractors, or other entities that have been contracted by the carrier or the provider to perform duties applicable to this section.

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

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

§ 38.2-3556. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Adverse determination" means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

"Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

"Artificial intelligence" means a machine-based system that undertakes analysis, reasoning, and problem solving, and that can be used to generate predictions, recommendations, or other content.

"Authorized representative" means (i) a person to whom a covered person has given express written consent to represent the covered person in an external review, (ii) a person authorized by law to provide substituted consent for a covered person, or (iii) a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

"Best evidence" means evidence based on (i) randomized clinical trials; if randomized clinical trials are not available, then (ii) cohort studies or case-control studies; if clauses (i) and (ii) are not available, then (iii) case-series; or if clauses (i), (ii), and (iii) are not available, then (iv) expert opinion.

"Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

"Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

"Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

"Certification" means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

"Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

"Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

"Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions or a serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

"Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

"Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of

individual patients.

"Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

"Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review entity, at the completion of the health carrier's internal appeal process.

"Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with the laws of the Commonwealth.

"Health care provider" or "provider" means a health care professional or a facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity, subject to the insurance laws and regulations of the Commonwealth or subject to the jurisdiction of the Commission, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and sickness insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or a nonstock corporation offering or administering a health services plan, a hospital services plan, or a medical or surgical services plan, or any other entity providing a plan of health insurance, health benefits, or health care services except as excluded under § 38.2-3557.

"Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

"Medical or scientific evidence" means evidence found in (i) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; (ii) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medica (EMBASE); (iii) medical journals recognized by the Secretary of Health and Human Services under § 1861(t)(2) of the federal Social Security Act; (iv) the following standard reference compendia: the American Hospital Formulary Service Drug Information; Drug Facts and Comparisons; the American Dental Association Accepted Dental Therapeutics; the United States Pharmacopeia -- Drug Information; National Comprehensive Cancer Network's Drugs & Biologics Compendium; and Elsevier Gold Standard's Clinical Pharmacology; (v) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal Agency for Healthcare Research and Quality, the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, the Centers for Medicare and Medicaid Services, the federal Food and Drug Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or (vi) any other medical or scientific evidence that is comparable to the sources listed in clauses (i) through (v).

"NAIC" means the National Association of Insurance Commissioners.

"Prospective review" means utilization review conducted prior to an admission or a course of treatment.

"Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention and includes study of the groups for variables and anticipated outcomes over time.

"Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

"Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

"Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

"Utilization review entity" means an individual or entity that conducts utilization review.

§ 38.2-3570.1. Use of artificial intelligence; right to expedited review; civil penalties.

A. No health carrier shall rely exclusively on artificial intelligence or automated decision tools to deny, reduce, or alter coverage or claims for medically necessary care. Adverse determinations shall be reviewed by physicians or other licensed health care professionals who are qualified in the appropriate specialties, without conflicts of interest or incentives to confirm adverse determinations, and who have the authority to reverse adverse determinations based on their clinical judgement. Health carriers shall conduct ongoing monitoring, audits, and oversight of all employees and third parties using artificial intelligence on their behalf to manage a covered person's coverage or claims, including taking actions to ensure that:

1. Medically necessary care to the covered person has not been delayed, denied, or limited;

2. Financial and administrative burdens on a covered person and health care providers are reasonable and minimized;

3. Private health information of a covered person is protected as required under the laws of the Commonwealth and federal privacy laws; and

4. Artificial intelligence use does not violate the rights of a covered person under the laws of the Commonwealth and federal laws prohibiting discrimination, including those based on age, race, sex, sexual orientation, and preexisting conditions.

B. A covered person or his authorized representative may make a request for an expedited external review with the Commission at the time the covered person receives an adverse determination after receiving notice pursuant to § 38.2-3407.15 that artificial intelligence was used in such adverse determination. The Commission shall conduct such external expedited review in the same manner as is required in accordance with § 38.2-3562.

C. Notwithstanding any other provision of law, a covered person shall have a private right of action to enforce the provisions of this section. In addition, the Commission may order as a remedy to a violation of this section:

1. Changes to or limitations on how health carriers use artificial intelligence for management of coverage and claims;

2. Civil penalties of up to $50,000 per violation;

3. The revocation or suspension of a health carrier's license; and

4. Compensation and damages to an affected covered person and health care providers, including pharmacies and hospitals.

D. For purposes of this section, "medically necessary care" means a medical, surgical, or other service required for the prevention, diagnosis, cure, or treatment of a health-related condition, including any such services that are necessary to prevent or slow a decremental change in either medical or mental health status.