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HOUSE BILL NO. 481

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on March 2, 2026)

(Patron Prior to Substitute—Delegate Hope)

A BILL to amend and reenact §§ 38.2-3407.15:2, as it is currently effective and as it shall become effective, and 38.2-3407.15:8 of the Code of Virginia, relating to prior authorization; requiring physician review for denial.

Be it enacted by the General Assembly of Virginia:

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

§ 38.2-3407.15:2. (Effective until January 1, 2027) 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; (iv) links directly to real-time patient out-of-pocket costs for the 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. *No carrier shall make an adverse determination, as defined in § 38.2-3556, of a prior authorization request for prescription drugs unless such adverse determination has been reviewed and approved by a licensed physician or, if a licensed physician is not available, a licensed pharmacist.*

F. 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.

§ 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 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; (iv) links directly to real-time patient out-of-pocket costs for the 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. *No carrier shall make an adverse determination, as defined in § 38.2-3556, of a prior authorization request for prescription drugs unless such adverse determination has been reviewed and approved by a licensed physician or, if a licensed physician is not available, a licensed pharmacist.*

F. 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.

§ 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 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 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.

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

requirements for each service on the list, including those services where prior authorization is performed by an entity under contract with the carrier, provided, however, that if the prior authorization was already required prior to January 1, 2027, the carrier may indicate an effective date of January 1, 2027.

D. ~~A~~ *No* carrier shall ~~not~~ deny a claim for failure to obtain prior authorization if the prior authorization requirements for the date of service were not posted on the publicly accessible website or other electronic application in accordance with subsection C.

E. *No carrier shall make an adverse determination, as defined in § 38.2-3556, of a prior authorization request for health care services unless such adverse determination has been reviewed and approved by (i) a licensed physician; (ii) in the case of mental health services, a licensed mental health provider if a licensed physician is unavailable; or (iii) in the case of dental services, a licensed dentist if a licensed physician is unavailable.*

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

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

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

~~H.~~ *I.* The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

~~I.~~ *J.* 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.