CHAPTER 881

An Act to amend and reenact §§ 38.2-3407.15 and 38.2-3407.15:8, as it shall become effective, of the Code of Virginia and to amend and reenact the second enactment of Chapter 474 and the second enactment of Chapter 475 of the Acts of Assembly of 2023, relating to health insurance; ethics and fairness in carrier business practices; downcoded claims; prior authorization; required contract provisions.

[S 164]

Approved April 13, 2026

Be it enacted by the General Assembly of Virginia:

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

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

A. As used in this section:

"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. *No carrier or intermediary, administrator, or representative of a carrier shall downcode a claim unless the decision to downcode is determined by a natural person or an electronic system that reflects correct coding standards and considers all relevant patient data documented by the billing provider on the claim submission in such determination. Any carrier, intermediary, administrator, or representative that downcodes a claim shall notify the provider submitting the claim that such claim has been downcoded and shall identify the associated claim adjustment reason codes and remittance advice remark codes on the explanation of payment. Each carrier shall include in the provider contract the process for disputing downcoded claims, including a reasonable timeline for the submission of a dispute that is at least 180 days*

after receipt of notice of a downcoded claim and reasonable timelines for the adjudication of a dispute and any subsequent appeal. All downcoding dispute decisions shall be reviewed and adjudicated by a natural person. The process to initiate a dispute for a downcoding decision shall be included on the explanation of payment. A person disputing more than one claim that was downcoded by a carrier, intermediary, administrator, or representative may dispute in batches of claims for each individual patient in accordance with the provider contract and the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.) and any rules, regulations, or procedures adopted pursuant thereto. No provision of this subdivision shall apply to limited-scope benefits, including stand-alone dental plans.

c. 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.

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.

§ 38.2-3407.15:8. (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~~ *means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability, including medical items and services. "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*;*

6. Require a carrier to establish and maintain a prior authorization application programming interface as described in 42 C.F.R. § 422.122(b) for processing prior authorization requests from providers for medical items and services that aligns with the requirements and standards for impacted payers under plan and product types regulated by the U.S. Centers for Medicare and Medicaid Services. A carrier shall implement

such prior authorization application programming interface by January 1, 2027, or any other effective date subsequently issued by the Centers for Medicare and Medicaid Services, including those related to enforcement delays and suspensions; and

7. Require a participating health care provider, within one year after the date required for implementing a prior authorization application programming interface pursuant to subdivision 6, to ensure that any electronic health record or health information technology system owned by or contracted for the provider to maintain the health record of an enrollee has the ability to access such application programming interface. A provider may request a waiver of compliance under this subdivision for undue hardship for a period determined by the appropriate regulatory agency of the Secretariat of Health and Human Resources.

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

I. 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.

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

**2. That the State Corporation Commission's Bureau of Insurance (the Bureau) shall, in coordination with the Secretary of Health and Human Resources, establish a work group to (i) monitor ~~anticipated federal developments related to~~ the implementation of electronic prior authorization for medical items and services, ~~(ii) assess~~ *pursuant to § 38.2-3407.15:8 of the Code of Virginia, including any relevant federal developments,* industry progress and readiness to implement electronic prior authorization for medical items and services, and ~~(iii) evaluate~~ policies supporting the effective and efficient adoption of electronic prior authorization for medical items and services*; (ii) monitor and consider options for revising the prior authorization process for prescription drugs from a less retrospective to a more prospective process; and (iii) consider whether the scope of prior authorization metrics reporting described in § 38.2-3407.15:8 of the Code of Virginia should be expanded to include prescription drugs, recognizing the practical aspects of implementation on a timeline consistent with medical items and services, the uncertainty around the timeline for any federal action and the form any such reporting might take, and the desire to conform any state requirements to those adopted at the federal level*. The work group shall include relevant stakeholders, including representatives from the Virginia Association of Health Plans, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia ~~Pharmacists~~ *Pharmacy* Association, and other *interested* parties ~~with an interest in the underlying technology~~. The work group shall report its findings and recommendations to the ~~Chairmen~~ *Chairs* of the Senate Committees on Commerce and Labor and Education and Health and the House Committees on *Labor and* Commerce ~~and Energy~~ and Health~~, Welfare and Institutions~~

and Human Services **annually by November 1 and shall make its final report by November 1, 2028.** ~~**In its November 1, 2025 report, the work group shall provide a final assessment of progress toward implementing electronic prior authorization and real-time cost benefit information for prescription drugs in the Commonwealth and shall recommend a date by which health carriers and providers shall implement electronic prior authorization for medical items and services.**~~