

SENATE BILL NO. 428

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor

on \_\_\_\_\_)

(Patron Prior to Substitute--Senator Dunnivant)

A BILL to amend and reenact § 38.2-3407.15:2 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.15:7, relating to health insurance; carrier disclosure of certain information.

**Be it enacted by the General Assembly of Virginia:**

**1. That § 38.2-3407.15:2 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3407.15:7 as follows:**

**§ 38.2-3407.15:2. 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;

27           2. Require that the carrier communicate to the prescriber or his designee within 24 hours, including  
28 weekend hours, of submission of an urgent prior authorization request to the carrier, if submitted  
29 telephonically or in an alternate method directed by the carrier, that the request is approved, denied, or  
30 requires supplementation;

31           3. Require that the carrier communicate electronically, telephonically, or by facsimile to the  
32 prescriber or his designee, within two business days of submission of a fully completed prior authorization  
33 request, that the request is approved, denied, or requires supplementation;

34           4. Require that the carrier communicate electronically, telephonically, or by facsimile to the  
35 prescriber or his designee, within two business days of submission of a properly completed  
36 supplementation from the prescriber or his designee, that the request is approved or denied;

37           5. Require that if the prior authorization request is denied, the carrier shall communicate  
38 electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes  
39 established by subdivision 3 or 4, as applicable, the reasons for the denial;

40           6. Require that prior authorization approved by another carrier be honored, upon the carrier's  
41 receipt from the prescriber or his designee of a record demonstrating the previous carrier's prior  
42 authorization approval or any written or electronic evidence of the previous carrier's coverage of such  
43 drug, at least for the initial 30 days of a member's prescription drug benefit coverage under a new health  
44 plan, subject to the provisions of the new carrier's evidence of coverage;

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

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

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

55           10. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless of  
56 whether the covered person changes plans with the same carrier and the drug is a covered benefit with the  
57 current health plan;

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

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

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

74           14. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless of  
75 whether the drug is removed from the carrier's prescription drug formulary after the initial prescription for  
76 that drug is issued, provided that the drug and prescription are consistent with the applicable provisions  
77 of subdivision 13;

78 15. Require a carrier, beginning July 1, 2025, notwithstanding the provisions of subdivision 1 or  
79 any other provision of this section, to establish and maintain an online process that (i) links directly to e-  
80 prescribing systems, electronic health record systems, and health information exchange platforms that  
81 utilize the National Council for Prescription Drug Programs SCRIPT standard; (ii) can accept electronic  
82 prior authorization requests from a provider; (iii) can approve, in real time, electronic prior authorization  
83 requests for which no additional information is needed by the carrier to process the prior authorization  
84 request and that meet the carrier's criteria for approval; and (iv) otherwise meets the requirements of this  
85 section; and

86 16. Require a participating health care provider to ensure any e-prescribing system, electronic  
87 health record system, or health information exchange platform used by the provider to maintain an  
88 enrollee's health record is linked directly to the electronic prior authorization process established by a  
89 carrier as required by subdivision 15 and the real time cost information data for a covered prescription  
90 drug made available by a carrier pursuant to § 38.2-3407.15:7.

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

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

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

97 1. Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.  
98 (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the  
99 Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or  
100 10 U.S.C. § 1071 et seq. (TRICARE);

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

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

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

111 **§ 38.2-3407.15:7. Carrier disclosure of certain prescription drug information upon request.**

112 A. As used in this section:

113 "Carrier" has the same meaning as provided in § 38.2-3407.15.

114 "Cost-sharing requirement" has the same meaning as provided in § 38.2-3438.

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

116 "Pharmacy benefits manager" has the same meaning as provided in § 38.2-3465.

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

118 B. Beginning July 1, 2025, any carrier or its pharmacy benefits manager shall furnish, upon  
119 request, to a provider acting on behalf of a an enrollee, real time cost information data for a covered  
120 prescription drug, including any cost-sharing requirement or prior authorization requirements, and shall  
121 ensure that the data is accurate at the time of the request. Such cost information data shall be available to  
122 the provider through the provider's e-prescribing system, electronic health record system, or health  
123 information exchange platform that utilizes the National Council for Prescription Drug Programs SCRIPT  
124 standard from which the provider makes the request.

125 **2. That the State Corporation Commission's Bureau of Insurance (the Bureau) shall, in coordination**  
126 **with the Secretary of Health and Human Resources, establish a work group to make**  
127 **recommendations regarding the implementation of electronic prior authorization as required by**  
128 **this act, including any recommendations for necessary statutory or regulatory changes. The work**  
129 **group shall include relevant stakeholders, including representatives from the Virginia Association**  
130 **of Health Plans, the Medical Society of Virginia, and the Virginia Hospital and Healthcare**

**131 Association. The work group shall report its findings and recommendations to the Chairmen of the**  
**132 Senate Committee on Commerce and Labor and the House Committee on Commerce and Energy**  
**133 by November 1, 2023.**

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