2026 General Assembly Legislation Summary

Carrier Business Practices

Last Updated May 26, 2026

During the 2026 General Assembly Session, legislators continued their work to strengthen clinical oversight, transparency, and consistency in insurance prior authorization and claims processes. This document provides a summary of the changes to law and provides background and guidance to assist you in compliance.

If you have any questions or require additional information, please contact Brent Rawlings brawlings@vhha.com or Julie Dime jdime@vhha.com.

Summary

AMENDS EXISTING LAW

HB481 **(Hope)** prohibits a health insurance carrier from denying or making an adverse determination of a prior authorization request for prescription drugs or health care services unless such denial has been reviewed and approved by a licensed physician or licensed pharmacist if a licensed physician is not available. **The law is effective July 1, 2026.**

HB484 **(Shin)/** SB164 **(McPike)** prohibits a carrier, intermediary, administrator, or representative of a carrier from downcoding a claim, as defined in the bill, unless the decision to downcode is determined by a person or electronic system that considers all relevant patient data from the billing provider in making the determination. The bill requires a carrier, intermediary, administrator, or representative that downcodes a claim to provide certain notice to the person submitting the claim, including the reason for the decision and the process to appeal. The bill requires that all downcoding dispute decisions shall be adjudicated by a natural person. The provisions of this subsection do not apply to limited-scope benefits, including stand-alone dental plans. **The law is effective July 1, 2026.**

HB676 **(Maldonado)/** SB172 **(Pekarsky)** states if the carrier requires information from the provider to establish medical necessity, benefit coverage, or precertification or authorization of services, or to conduct reconsideration activities, the provider may submit and the carrier shall accept such information as electronic information or an electronic attachment. In submitting such information as electronic information or an electronic attachment, the provider may be required to comply with the standards, formats, and implementation specifications adopted by the U.S. Department of Health and Human Services, as amended and where applicable. The legislation includes a delayed enactment specifying that the provisions of the act shall not become **effective until January 1, 2027.**

HB736 **(Maldonado)** amends existing required provisions for health carrier contracts related to prior authorizations for prescription drugs. Current law requires that if prior authorization is approved for prescription drugs and such prescription drugs have been scheduled, provided, or delivered to the patient consistent with the authorization, health carriers may not revoke, limit, condition, modify, or restrict that authorization except in certain circumstances. The bill requires this limitation on carriers to apply for a minimum of six months for initial authorizations and a minimum of 12 months for continued authorizations. The bill adds circumstances under which a prior authorization may be revoked, limited, conditioned, modified, or restricted by a carrier, including (i) a final action by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer communicating a patient efficacy issue that would affect the authorization and (ii) when additional safety monitoring is recommended by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer. **The law is effective July 1, 2026.**

Action Required

HB481

Hospitals and provider organizations will need to update workflows to ensure prior authorization denials are clinically reviewed.

HB484/SB164

Hospitals and provider organizations will need to update workflows to address downcoding protections, track claims activity, and manage disputes and appeals within required timeframes. Additionally, organizations will need to revise policies, coordinate with carriers, and train staff to support compliance with new administrative requirements.

HB676/SB172

Hospitals and provider organizations will need to update workflows and adjust internal processes to ensure carrier compliance with permitting requests for additional information and supplemental documentation to be submitted electronically. Additionally, organizations should evaluate the need to align internal policies, provider contracts, and staff training to support electronic transactions, improve documentation practices, and coordinate closely with carriers to ensure compliance with updated claims processing and communication standards.

HB736

Hospitals and provider organizations will need to evaluate the need for any changes to existing policies and procedures related to how prior authorizations for prescription drugs are managed from both a clinical and administrative perspective. This includes ensuring timely submission and follow-up on requests, maintaining clear records and tracking systems, and understanding when approvals must remain in place for defined periods with only limited exceptions. Providers will also need to confirm their technology systems can support electronic prior authorization and access real-time benefit information, while updating internal guidance and training staff to align with new expectations around communication, documentation, and continuity of care.

Background Information

These bills were introduced to address longstanding concerns from providers about administrative burden, delays in care, and lack of transparency in insurer prior authorization and claims practices. Throughout the legislative process, VHHA worked closely with patrons and stakeholders to highlight the significant operational challenges created by antiquated carrier systems, particularly the time and resources required to navigate complex and often manual appeal processes. These pieces of legislation aim to improve patient access and continuity of care by ensuring clinical oversight of prior authorization denials, limiting arbitrary changes to approved treatments, and establishing more consistent timeframes and standards for decision-making. It also increases transparency in claims processing and advances the use of electronic transactions, reflecting a broader effort to modernize interactions between providers and insurers and reduce administrative burden.

Statutory Text

(NOTE: The language in *italics* and ~~strikethrough~~ are the only changes to the law. All other language and requirements under the law remain unchanged.)

HB481

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. 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.

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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. 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.

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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.

HB484/SB164

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:

. . .

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.*

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§ 38.2-3407.15:8. 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:

. . .

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.

. . .

**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 repot, 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.~~

HB676/SB172

1. That § 38.2-3407.15 of the Code of Virginia is 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*, provided, however, that when such additional documentation is requested, the provider may submit and the carrier shall accept such documentation as an electronic attachment. No carrier shall require submission of such documentation by paper, facsimile, or other nonelectronic means if an electronic attachment can be used*.

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. *When such information is requested, the provider may submit and the carrier shall accept such information as electronic information or an electronic attachment. In submitting such electronic information or electronic attachment, the provider may be required to comply with the standards, formats, and implementation specifications adopted by the U.S. Department of Health and Human Services, as amended and where applicable, and with the processes and procedures for electronic information outlined in the provider contract. A carrier shall not be required to accept electronic information or an electronic attachment submitted in nonstandard or noncompliant formats where applicable federal standards exist. A carrier shall not require submission of such information by paper, facsimile, or other nonelectronic means when the provider has submitted it as electronic information or an electronic attachment that is compliant with the standards referenced above and the processes and procedures for electronic information or an electronic attachment outlined in the provider contract.* 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. *The date of transmission of electronic information or an electronic attachment that is compliant with the standards referenced above and the processes and procedures outlined in the provider contract shall be considered the date on which the claim was received for the purposes of timely payment as required under this section.* No carrier may *shall* 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~~ *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 the carrier requires information from the provider to establish medical necessity, benefit coverage, or pre-certification or authorization of services, or to conduct reconsideration activities, the provider may submit and the carrier shall accept such information as electronic information or an electronic attachment. In submitting such information as electronic information or an electronic attachment, the provider may be required to comply with the standards, formats, and implementation specifications adopted by the U.S. Department of Health and Human Services, as amended and where applicable. A carrier shall not be required to accept electronic information submitted in nonstandard or noncompliant formats. A carrier shall not require submission of such documentation by paper, facsimile, or other nonelectronic means when the provider has submitted it as electronic information or an electronic attachment that is compliant with the standards referenced above and the processes and procedures for electronic information or an electronic attachment outlined in the provider contract.* 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~~ *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~~ *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~~ *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.

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

HB736

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

§ 38.2-3407.15:2. 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:

. . .

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*, for the duration of the authorization, which shall be no less than six months for initial authorizations and 12 months for continued authorizations,* 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 *or efficacy* issue that would affect the authorization alone or in combination with other authorizations; (iii) *additional safety and efficacy monitoring is clinically appropriate or recommended by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer; (iv)* a combination of drugs prescribed would cause a drug interaction; or ~~(iv)~~ *(v)* 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;

. . .

2. That the provisions of this act shall apply to contracts entered into, amended, or renewed on or after January 1, 2027.