Report of the Electronic Prior Authorization Work Group

Submitted to the Chairs of the Senate Committee on Commerce and Labor and the House of Delegates Committee on Commerce and Energy, pursuant to Chapters 284 and 285, Acts of Assembly – 2022 Session

November 1, 2022

COMMONWEALTH OF VIRGINIA

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November 1, 2022

Transmitted via Email

The Honorable Richard L. Saslaw, Chair
Commerce and Labor Committee
Senate of Virginia

The Honorable Kathy J. Byron, Chair
Commerce and Energy Committee
Virginia House of Delegates

Dear Chairs Saslaw and Byron:

Pursuant to Chapter 284 and Chapter 285, Acts of Assembly – 2022 Session (HB 360 and SB 428, respectively), the State Corporation Commission, in coordination with the Secretary of Health and Human Resources, submits this Report of the Electronic Prior Authorization Work Group on behalf of the participating stakeholders.

While the Bureau of Insurance within the Commission and the Health and Human Resources Secretariat staffed the work group and served as facilitators, this report represents the perspectives of the participating stakeholders.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

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Executive Summary

During its 2022 Session, the General Assembly passed HB 360[1] and SB 428[2] (ePA legislation) to modernize the prior authorization process for prescription drugs. If this ePA legislation is reenacted during the 2023 Session, the following provisions will take effect on July 1, 2025: one, carriers must implement an ePA process for prescription drugs; two, participating health care providers must ensure that any e-prescribing or electronic health record system they own or contract for can access the carrier's ePA process and the real-time cost information for a covered prescription drug that is made available by a carrier; and three, carriers or their pharmacy benefits managers (PBM) must provide real-time cost information to enrollees and contracted providers for a covered prescription drug, including any cost-sharing and prior authorization requirements.[3]

In the interim, the ePA legislation directed the State Corporation Commission (Commission), in coordination with the Secretary of Health and Human Resources, to establish a stakeholder work group to evaluate and make recommendations to modify the process for prior authorization for drug benefits to maximize efficiency and minimize delays.

The work group submits this report of its findings and recommendations. While the Commission's Bureau of Insurance (Bureau) and the Health and Human Resources Secretariat (HHR Secretariat) staffed the work group and served as facilitators, this report represents the perspectives and consensus of the participating stakeholders.

The work group recommends that Virginia move forward with implementing the 2022 ePA legislation and make these provisions permanent. It also recommends that in the run up to July 1, 2025, the Bureau, together with the Secretary of Health and Human Resources, continue to provide a forum for stakeholders to meet and assess progress towards implementing ePA and real-time cost information for prescription drugs.

The work group agreed on four changes to the 2022 legislation: one, specify that the online process is to link directly to all e-prescribing systems and electronic health record systems using the SCRIPT standard; two, clarify the provision prohibiting carrier fees and charges for providers to access the online process; three, impose a readiness deadline; and four, revise the waiver provision to have the term set by regulation rather than statute. The work group did not achieve consensus on another six proposals.

The work group also made 16 findings. Chief among these was the recognition that automating the prior authorization process for prescription drugs will help streamline and accelerate the disposition of prior authorization requests and, working in tandem with real-time benefit tools, will improve the patient experience and reduce the burden on all involved. Further, it found that Virginia health plans are technologically ready to implement ePA and real time cost information. Finally, the work group found that Virginia will become one of 32 states that have addressed ePA for prescription drugs if the General Assembly reenacts the legislation as recommended.

Introduction

During its 2022 Session, the Virginia General Assembly passed HB 360 and SB 428 (ePA legislation) to modernize the prior authorization process for prescription drugs. A key component is the use of online processes known as ePA to manage prior authorization requests.

The National Council for Prescription Drug Programs (NCPDP), a not-for-profit, nationally accredited, standards development organization representing virtually every sector of the pharmacy services industry,[4] describes prior authorization as follows:

> Prior authorization is the process that is used to request coverage of a specific medication for a specific patient. Generally, the prescriber requests the authorization from a "Payer" (health plan, processor, or Pharmacy Benefit Manager). The Payer determines whether it will pay for the medication based on a number of factors, such as medical necessity, prior treatment, clinical indications, and total cost of therapy. This process has historically been handled via facsimile exchange of information or telephone call, and only recently via payer-specific web portals.[5]

If the General Assembly reenacts this ePA legislation during its 2023 Session, the following provisions will take effect in Virginia beginning July 1, 2025:

- Carriers must implement an ePA process for prescription drugs;
- Participating health care providers must ensure that any e-prescribing or electronic health record system they own or contract for can access the carrier's ePA process and the real-time cost information for a covered prescription drug that is made available by a carrier within that same time frame; and
- Carriers or their PBMs must provide real-time cost information to enrollees and contracted providers for a covered prescription drug, including any cost-sharing requirement and prior authorization requirements.[6]

In the interim, the ePA legislation directed the Commission, in coordination with the Secretary of Health and Human Resources, to establish a work group of specified stakeholders "to evaluate and make recommendations to modify the process for prior authorization for drug benefits to maximize efficiency and minimize delays." It further required that these recommendations include a single standardized process "as required by this act"[7] and "any recommendations for necessary statutory or regulatory changes."

The statutorily designated members of the work group consisted of representatives from the Virginia Association of Health Plans, the Medical Society of Virginia, the NCPDP, the Virginia Pharmacists Association, and the Virginia Hospital and Healthcare Association, and other parties with an interest in the underlying technology. The Commission, through the Bureau, and the HHR Secretariat established an inclusive and transparent process, welcoming broad participation from more than forty individuals in

five virtual meetings. All were given the opportunity to participate in the discussions and submit suggested findings and recommendations.

In accordance with the statutory directive, the work group hereby submits this report of its findings and recommendations to the Chairs of the Senate Committee on Commerce and Labor and the House Committee on Commerce and Energy. While the Bureau and the HHR Secretariat staffed the work group and served as facilitators, this report represents the perspectives and consensus of the participating stakeholders.

Primary Consensus Recommendations

As its primary recommendation, the work group recommends that Virginia move forward with the process of implementing the provisions of the ePA legislation – those related to establishing an electronic prior authorization process for prescription drugs and providing real-time cost information, beginning July 1, 2025. This online process is the "single standardized process" that the work group is tasked with including among its recommendations. The General Assembly should make these provisions permanent by striking the 2023 re-enactment requirement in the third enacting clause of the ePA legislation and incorporating the other consensus recommendations included in this report.

> Proposed revision: ~~3. That the provisions of the first enactment of this act shall not become effective unless reenacted by the 2023 Session of the General Assembly.~~

The work group also recommends that in the lead up to July 1, 2025, the Bureau, together with the Secretary of Health and Human Resources, continue to provide a forum for stakeholders to meet and assess progress towards implementing electronic prior authorization and real-time cost benefit information for prescription drugs, including monitoring and evaluating the impact of any federal and state developments, and discussing and recommending any last-minute changes to facilitate implementation. We recommend that an annual update be provided to the Chairs of the Senate Commerce and Labor and Education and Health Committees, and the House Commerce and Energy and Health, Welfare, and Institutions Committees. The General Assembly should replace the language in the second enacting clause[8] of the ePA Legislation with the following:

> Proposed revision: <u>2. Prior to July 1, 2025, the Bureau of Insurance, in coordination with the Secretary of Health and Human Resources, shall provide a forum for relevant stakeholders to meet and assess progress towards implementing electronic prior authorization and real-time cost benefit information for prescription drugs, including monitoring and evaluating the impact of any federal and state developments and discussing and recommending any additional statutory changes required to facilitate implementation. Relevant</u>

stakeholders shall include representatives from the Virginia Association of Health Plans, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Pharmacists Association, and other parties with an interest in the underlying technology. Annual updates shall be provided to the Chairs of the Senate Commerce and Labor and Education and Health Committees, and the House Commerce and Energy and Health, Welfare, and Institutions Committees, on or before November 1.

Other Consensus Recommendations

In addition to its primary recommendations, the work group agreed on four additional recommendations:

1. Strengthen the language around the development and implementation of the carrier tools on the front end to minimize launch inefficiencies. Insert the word "all" in subdivision 15 of the amendments to § 38.2-3407.15:2. B. in Chapters 284 and 285 of the Acts of Assembly such that the online system will link directly to "all" prescribing and electronic health records systems that use the NCPDP's SCRIPT standard.

> Proposed revision: "15. Require a carrier, beginning July 1, 2025, notwithstanding the provisions of subdivision 1 or any other provision of this section, to establish and maintain an online process that (i) links directly to all e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Program's SCRIPT standard;…"

2. Amend subdivision 15 of the amendments to § 38.2-3407.15:2. B. in Chapters 284 and 285 of the Acts of the Assembly to further clarify that providers will not incur fees or charges to access the online process established by the carriers. According to industry representatives participating in the work group meetings, a new online process should not result in any additional fees or charges for providers. They indicated that the industry practice has been to allow providers to use vendor technologies to access ePA (e.g., to process individual ePAs) and/or other real-time prescription benefit information without charge. However, according to one proponent, carriers provide free "access," but then limit the functionality of this "free" tier. From a practical standpoint, this can effectively force a provider to upgrade to "premium" features that should be included in a free tier. Although agreeing to this recommendation, one proponent expressed concerns that it does not prevent information technology vendors from imposing interface fees and charges on providers. If providers must access data through several third-party vendors, the aggregate costs of such fees could become substantial for some providers. The proponents recommend that these potential costs be further explored, and mitigated as much as possible, in the run-up to implementation.

Proposed revision: "…No carrier shall (a) impose a fee or charge ~~or fee~~ on any person ~~a participating health care provider~~ for accessing the online process as required by this subdivision…"

3. Amend subdivision 15 of the amendments to § 38.2-3407.15:2. B. in Chapters 284 and 285 of the Acts of the Assembly to add a "readiness deadline" for health plans and their vendors of at least one year prior to the implementation date. Depending on the inevitable variation in vendor requirements, time will be needed for providers to operationalize the systems and processes for all health plans. Therefore, the work group believes it is critical for providers and their vendors to have sufficient lead time for programming, testing, and training. A July 1, 2025, deadline will only be realistic if all the necessary information for implementation is known at least a year in advance. The following proposed language is preliminary and can be further developed:

Proposed addition: "~~:~~. No later than July 1, 2024, carriers shall provide the names and contact information of the third-party vendors or other entities they will use for data interchange related to the requirements in this section and section 38.2-3407.15:7 to all providers requesting this information. Posting the information on a publicly accessible web site will satisfy the requirements of this provision; and …"

4. Amend subdivision 16 of the amendments to § 38.2-3407.15:2. B. in Chapters 284 and 285 of the Acts of the Assembly, to have the duration of the provider hardship exemption determined by a regulatory authority within the HHR Secretariat with responsibility for administering other hardship exemption processes, rather than placing it in the statute. Appearing before the work group, a representative from the Maryland Health Care Commission stated that in the case of health plan waivers, they had changed the length of their waiver from one year to two years and are now planning to change it to five years. This potential fluidity can best be addressed through the regulatory process.

Proposed revision: "… A provider may request a waiver of compliance under this subdivision for undue hardship for a period specified by the appropriate regulatory authority within the Health and Human Resources Secretariat ~~not to exceed 12 months~~."

Recommendations Not Adopted

The work group considered several other stakeholder suggestions but did not reach consensus on these. Therefore, they are not part of the work group's recommended revisions to the 2022 ePA legislation. Many of these proposed recommendations were thought to be beyond the scope of the work group or premature, and/or were supported by a single proponent. These included the following:

1. Require carriers to respond in real time to ePA requests that require no supplementation, within 30 minutes to urgent requests, and within 2 hours to normal requests when the electronic prior authorization process is used and supplementation is required. Additionally, if carriers do not issue prior authorization decisions within the required time periods, then the prior authorization request should be deemed approved, and the carrier should not be allowed thereafter to deny payment. According to carriers, a prior authorization request should never be deemed approved by default. Opponents generally felt the proposed time frames were unrealistic, although there was agreement that ePA should help accelerate response times once fully implemented. However, changing timeframes now was seen as premature by others. Many felt that further consideration should be tabled until the law is implemented, and actual data is available. The single proponent of these specific timeframes indicated that the principle is more important than the specific numbers.

2. Revise the online ePA process established by a carrier to require use of a standardized prior authorization form. According to the sole proponent, the efficiencies of an ePA process would do little to streamline prior authorization if each carrier and PBM have different methods with different requirements. With more than 300 different prior authorization forms, the proponent viewed a standardized form as integral to establishing and maintaining a standardized online process. Those opposed to this proposal were concerned that requiring the use of a standardized form would limit the flexibility needed to provide different carrier benefit designs and options to employers and their health plan enrollees.

3. Incentivize provider use of ePA. Approximately 80% of current prior authorization requests are processed through a retrospective workflow, with prior authorization initiated after the prescription has been sent to the pharmacy rather than at the point of prescribing. The work group members generally thought that implementing the move to ePA and the shift to a prospective workflow would be incentive enough for providers.

4. Include a statement that ePA should not limit access and patient choice by steering patients to specific pharmacies by a health plan or a PBM. This proposal had one proponent. It was offered to increase efficiency and minimize delays at the pharmacy. Those opposed agreed it was premature to address this proposed recommendation or thought it was outside of the scope of the work group but suggested that it be monitored to see if it becomes a problem once ePA has been fully implemented. In addition, carriers felt such a proposal would undermine them, and the employers they support, as well as their ability to create cost savings and improve patient quality of care.

5. Permit pharmacists to file a prior authorization request on behalf of a patient. The proponent argued that a pharmacist is perfectly positioned to know and gather medical history for a patient, particularly if a diagnosis code is included with the prescription and should have the opportunity to complete a prior authorization on behalf of the patient. Another participant voiced support since most prior authorizations now occur

retrospectively. Ultimately, it was viewed as being beyond the work group charge and more appropriate as a separate scope of practice bill.

6. Authorize pharmacists to provide therapeutic interchange and prescription adaptation services in community pharmacy settings. According to the proponent, a physician might write for a specific therapy that is not on a formulary, resulting in the need to use a prior authorization. This step could be avoided if the pharmacist were authorized to change the therapy to align with the patient's formulary. Proponents characterized this initiative as one that would "maximize efficiency and minimize delays" on the patient end. Those opposed to this proposal generally agreed that it was beyond the scope of the work group.

Findings

Finding 1: According to a survey of commercial health plans, 83% of enrollees are in health plans where prior approval is limited to no more than 10% of prescription drugs. Seven percent are in health plans where 25% or more of prescription drugs require prior authorization.[9] Prior authorization most commonly applies when high-cost brand name drugs are prescribed (70%), specialty drugs are prescribed (98%) and hi-tech imaging services (89%) are ordered.[10] Health plans may waive prior authorization for certain providers. Prior authorization typically has a greater impact on specialties such as rheumatology and psychiatry.

Finding 2: Automating the prior authorization process through ePA will help streamline and accelerate the disposition of prior authorization requests. From a strictly technical standpoint, providers can transmit 11 prior authorization requests electronically in the time it takes to do one manually via fax or phone.[11] With ePA, health care providers will spend less time and resources making phone calls to determine prior authorization requirements and will instead have the information available at the click of a button. According to one study presented to the work group, the "time to decision" for a prior authorization request for prescription drugs was more than three times faster with ePA than manually – 5.7 hours for ePA compared to 18.7 hours manually – a 69% reduction.[12] Also, after adopting ePA, nearly two-thirds of providers reported less time spent on phone calls and faxes.[13]

Finding 3: Thirty-two states have addressed ePA for prescription drugs. Including Virginia if the ePA legislation takes efffect, 16 require health plans to support ePA and 15 specifically allow ePA.[14] Of these,15 specify the NCPDP standard. Iowa, Tennessee, and Indiana have the highest ePA adoption rates.[15] The majority of state laws require health plans to act within a specific timeframe for initial requests, as well as emergency requests and appeals.[16]

Finding 4: ePA also works together with real time benefit tools to produce a better patient experience; reduce, but not eliminate, the burdens on patients, providers, and

pharmacists; and result in fewer abandoned medications. This combination can also reduce the need for prior authorization. With both ePA and real-time cost benefit information, pharmacists will spend less time calling the health care provider to get a prior authorization handled and save time spent on restocking and other costs associated with abandoned medication. In most cases, pharmacists deliver cost and eligibility information directly to the patient, retrospectively to the health care provider and patient discussion. While many pharmacists use electronic methods to process prior authorization requests, they often end up having to manually check for prior authorization status. This requires significant time and resources. Adding to this burden, when prescription costs exceed $125 per script, 52% of patients abandon their prescriptions at the point of sale (the pharmacy). The patient abandonment rate increases to 69% when the cost is above $250.[17]

Finding 5: The recent trend is to include ePA as part of a greater transparency effort that includes all of a patient's specific benefit information in real-time at the point of prescribing so that the provider and the patient can work together to determine what makes the best clinical and financial sense for the patient. While some patient benefit information may already be available to some providers, this information is not provided uniformly, and not all PBMs and health insurers provide it or make the information easily accessible. Requiring that a patient's benefit information be made available to providers in real time at the point of prescribing as part of the patient's electronic medical record is not the same as real-time ePA.

Finding 6: ePA for prescription drugs can be done effectively. Prospective workflow is the ideal solution so that prior authorization is secured before the patient arrives at the pharmacy. Yet fewer than one in five health care providers initiated prior authorization requests prospectively.[18] Health care providers have found that there is often no easy way within a patient's electronic medical record to verify prior authorization.[19] By creating a bridge between the various health care modules, Virginia's ePA law will help achieve this optimal workflow.

Finding 7: In the last two years, Tennessee, Ohio, Colorado, California, and Maine have enacted laws that require that a patient's real-time benefit information, including the need for prior authorization, is provided at the point of prescribing as part of the patient's electronic medical record. Legislation in New York is now awaiting signature by the Governor. Similar legislation is pending in Pennsylvania and Massachusetts. Since many of the state laws have only been in place a short time, states do not yet have data regarding the numbers of health care providers utilizing these real-time benefit systems, and do not have the numbers related to actual decreases in patient medication abandonment.[20]

Finding 8: Virginia health plans are technologically ready to implement ePA and real time cost and benefit legislation. Some health plans already have ePA processes in place for prescription drugs. As in Maryland, health plans may choose to construct their

own portal to meet ePA requirements. At the federal level, ePA for prescription drugs is already in place for Medicare Part D.

Finding 9: There are different ways providers can implement ePA processes in their electronic health records, although some providers do not use electronic health record systems enabled for ePA because of cost or other upgrade burdens. Some small medical practices will need a waiver until their technology can be fully integrated. Cost and flexibility between carriers, pharmacists, and consumers will be a key ingredient to successful implementation of ePA.

Finding 10: Presenters indicated that it has been the industry practice not to charge health care providers for technologies that provide ePA or other real-time prescription benefit information. Most providers independently negotiate their electronic medical record services contract with the technology vendors.

Finding 11: According to one health information network, "by the end of 2021, nearly one-half of U.S. prescribers were using its real-time prescription benefit service to access patient-specific benefit information, out-of-pocket costs and more affordable medication alternatives."[21] PBMs and health plans representing 98% and 99% of insured patients were contracted for the network's ePA and real-time prescription benefit service, respectively.[22] Among U.S. prescribers, 84% and 98% were served by contracted electronic health records vendors for ePA and real-time prescription benefit, respectively.[23] A health technology vendor indicated that "since January 2021, its real-time prescription benefit solution has been used by over 560,000 prescribers to view prescription benefit details, including out-of-pocket pricing and prior authorization notifications with 95% and 94% accuracy, respectively.[24] In the same timeframe, nearly 250,000 prescribers utilized its integrated ePA solution, connecting them with over 500,000 pharmacies and most health plans and PBMs."[25]

Finding 12: Virginia, consistent with all other states using ePA, has already adopted the standard necessary to support a single standardized ePA process for prescription drugs. This is the NCPDP's SCRIPT standard. Created in 2013 to facilitate the electronic transfer of prescription information between U.S. pharmacists and prescribers, the SCRIPT standard provides uniformity and makes the technological aspect of the ePA legislation work. More complexity and variation in the standards will complicate implementation and add costs.

Finding 13: The NCPDP has developed a real time benefit standard for prescription drugs that is now in use in the pharmacy industry. On January 1, 2022, the Centers for Medicare & Medicaid Services' (CMS) rule requiring Medicare Part D plans to support a prescriber real-time drug benefit tool went into effect. The rule requires health plans to provide at least one real time benefit tool capable of integrating with at least one prescriber's eRx system or electronic medical record. The CMS has been asked to name the NCPDP's standard as a new standard under this rule but has not yet done so.

Finding 14: Most Virginia health plans already provide the data to providers, primarily within their networks, to populate real time benefit tools. They also provide real time benefit tools to meet federal requirements. Real time benefit data technology is already integrated into most electronic health records.

Finding 15: The Virginia Medicaid fee-for-service program requires the administrator to provide an ePA solution as defined in the NCPDP's SCRIPT Standard and named in the Medicare Modernization Act; however, prescribers are not required to use it. Under the managed care program, the prior authorization process is administered by the PBMs for the managed care organizations (MCOs). Four of six MCOs have ePA operational within their PBMs. One other expects to be operational in fall 2023, while the sixth plans to be operational at an unspecified future implementation date.

Finding 16: While a medical prior authorization standard was named in HIPAA over 25 years ago, and subsequently updated, it has proven to be an unworkable solution and, as a result, its adoption has been hindered. The most recent federal regulations coming out of the U.S. Department of Health and Human Services (HHS) and the CMS to reduce the burden of prior authorization and move to an automated solution for medical services use newer and emerging standards – namely, the Fast Healthcare Interoperability Resources (FHIR). In December 2020, the CMS released the *Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information CMS-9123-P*: *Fact Sheet*, calling for the use of these newer FHIR based standards to increase the automation of medical prior authorization. While this proposed rule was subsequently pulled back, CMS continues to signal its intent to re-release these rules in 2022 and call for the use of the FHIR process to automate medical prior authorization.

Appendix A.

Chapter 284, Acts of Assembly – 2022 Session (identical to Chapter 285)

CHAPTER 284

*An Act 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.*

[H 360]

Approved April 8, 2022

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;

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

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

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

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

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

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

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

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

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

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

12. Require that no prior authorization be required for at least one drug prescribed for substance abuse medication-assisted treatment, provided that (i) the drug is a covered

benefit, (ii) the prescription does not exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board of Medicine;

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

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

15. Require a carrier, beginning July 1, 2025, notwithstanding the provisions of subdivision 1 or any other provision of this section, to establish and maintain an online process that (i) links directly to e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard; (ii) can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior authorization requests for which no additional information is needed by the carrier to process the prior authorization request, no clinical review is required, and that meet the carrier's criteria for approval; and (iv) otherwise meets the requirements of this section. No carrier shall (a) impose a charge or fee on a participating health care provider for accessing the online process required by this subdivision or (b) access, absent provider consent, provider data via the online process other than for the enrollee; and

*16. Require a participating health care provider, beginning July 1, 2025, to ensure that any e-prescribing system or electronic health record system owned by or contracted for the provider to maintain an enrollee's health record has the ability to access the electronic prior authorization process established by a carrier as required by subdivision 15 and the real-time cost information data for a covered prescription drug made available by a carrier pursuant to § **38.2-3407.15:7**. A provider may request a waiver of compliance under this subdivision for undue hardship for a period not to exceed 12 months*.

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

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

E. 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.

*§ **38.2-3407.15:7**. Carrier provision of certain prescription drug information.*

A. As used in this section:

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

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

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

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

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

B. Beginning July 1, 2025, any carrier or its pharmacy benefits manager shall provide real-time cost information data to enrollees and contracted providers for a covered prescription drug, including any cost-sharing requirement or prior authorization requirements, and shall ensure that the data is accurate. Such cost information data shall be available to the provider in a format that a provider can access and understand such as through the provider's e-prescribing system or electronic health record system

for which the carrier or pharmacy benefits manager or its designated subcontractor has adopted that utilizes the National Council for Prescription Drug Programs SCRIPT standard from which the provider makes the request.

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 evaluate and make recommendations to modify the process for prior authorization for drug benefits in order to maximize efficiency and minimize delays. Such recommendations shall include a single standardized process as required by this act and any recommendations for necessary statutory or regulatory changes. The work group shall include relevant stakeholders, including representatives from the Virginia Association of Health Plans, the Medical Society of Virginia, the National Council for Prescription Drug Programs, the Virginia Pharmacists Association, and the Virginia Hospital and Healthcare Association, and other parties with an interest in the underlying technology. The work group shall report its findings and recommendations to the Chairmen of the Senate Committee on Commerce and Labor and the House Committee on Commerce and Energy by November 1, 2022.

3. That the provisions of the first enactment of this act shall not become effective unless reenacted by the 2023 Session of the General Assembly.

Appendix B.

Electronic Prior Authorization Work Group Participants

State Government Resources

State Corporation Commission
Virginia Department of Medical Assistance Services
Virginia Department of Health
Virginia Secretary of Health and Human Resources

Stakeholder Organizations Represented

Aetna
America's Health Insurance Plans
Anthem
Arthritis Foundation
Association for Accessible Medicines
CareFirst BlueCross BlueShield
Cigna
CoverMyMeds
Evernorth
HCA Healthcare
McKesson
Medical Society of Virginia
National Council for Prescription Drug Programs
Pharmaceutical Care Management Association
Pharmaceutical Research and Manufacturers of America
Sentara
Surescripts
United Health Group
Virginia Academy of Family Physicians
Virginia Association of Health Plans
Virginia Hospital and Healthcare Association
Virginia Pharmacists Association

Endnotes

[1] Chapter 284, Acts of Assembly – 2022 Session.
[2] Chapter 285, Acts of Assembly – 2022 Session.
[3] Chapter 284 and 285, Acts of Assembly – 2022 Session (amending § 38.2-3407.15:2. B. and § 38.2-3407.15:7 of the Code of Virginia).
[4] "ePA Technological Readiness through Standard Setting," Presentation by M. Weiker and T. Strickland to the Electronic Prior Authorization Work Group (ePAWG), July 20, 2022.
[5] "NCPDP SCRIPT Standard Supports Electronic Prior Authorization (ePA): Fact Sheet," January 2015.
[6] Chapter 285, Virginia Acts of Assembly – 2022 Session, (amending § 38.2-3407.15:2. B. of the Code of Virginia).
[7] For purposes of this report, "act" in this context was understood to mean Chapters 284 and 285 of the Acts of Assembly – 2022 Session.
[8] The second enactment clause of the 2022 ePA legislation called for the creation of the work group and the completion of this report and would be replaced with the new language recommended by the work group.
[9] "Key Results of Industry Survey on Prior Authorization," AHIP, June 9, 2020. Survey responses were received from forty-four commercial health plans covering 109 million enrollees.
[10] "Key Results of Industry Survey on Prior Authorization," AHIP, June 9, 2020.
[11] "Electronic Prior Authorization: Fax or Fast," Express Scripts, 2014.
[12] "FastPATH Demo Project," Presentation by K. Berry to the ePAWG, AHIP, August 10, 2022.
[13] Calculators are available to determine provider savings from the use of ePA. For example, see https://surescripts.com/enhance-prescribing/priorauthorization?modal=ehr_integrated_electronic_prior_authorization
[14] "Comprehensive Prior Authorization Support to Help Impact More Patients," Presentation by T. Russell to the ePAWG, CoverMyMeds, August 10, 2022.
[15] "Comprehensive Prior Authorization Support to Help Impact More Patients," Presentation by T. Russell to the ePAWG, CoverMyMeds, August 10, 2022.
[16] Letter to Stephen Hogge from McKesson, August 24, 2022.
[17] Letter to Stephen Hogge from McKesson, September 20, 2022.
[18] "Comprehensive Prior Authorization Support to Help Impact More Patients," Presentationby T. Russell to the ePAWG, Cover My Meds, August 10, 2022.
[19] Letter to Stephen Hogge from McKesson, August 24, 2022.
[20] Letter to Stephen Hogge from McKesson, September 20, 2022.
[21] "National Progress Report 2021," Surescripts.
[22] "National Progress Report 2021," Surescripts.
[23] "National Progress Report 2021," Surescripts.
[24] Source: CoverMyMeds.
[25] Source: CoverMyMeds.