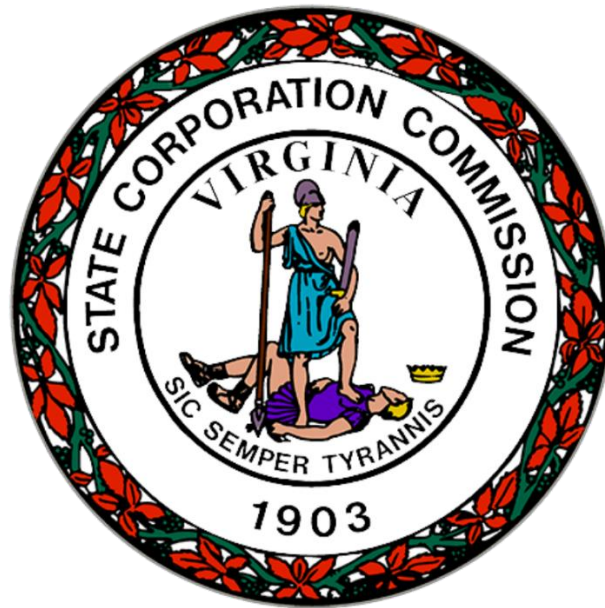


Report of the Prior Authorization Metrics Reporting Work Group

*Submitted to the Chairs of the Senate Committees on Commerce and Labor and
Education and Health; and Chairs of the House Committees on Labor and Commerce
and Health and Human Services, pursuant to Chapters 58 and 68
of the 2025 Acts of Assembly*



State Corporation Commission
Bureau of Insurance

November 1, 2025



COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

== COMMISSIONERS ==

JEHMAL T. HUDSON • SAMUEL T. TOWELL • KELSEY A. BAGOT

November 1, 2025

TRANSMITTED VIA EMAIL

The Honorable R. Creigh Deeds
Chair, Commerce and Labor Committee
Senate of Virginia

The Honorable Jeion A. Ward
Chair, Labor and Commerce Committee
Virginia House of Delegates

The Honorable Ghazala F. Hashmi
Chair, Education and Health Committee
Senate of Virginia

The Honorable Mark D. Sickles
Chair, Health and Human Services
Committee
Virginia House of Delegates

Dear Senator Deeds and Senator Hashmi, and Delegate Ward and Delegate Sickles:

On behalf of the State Corporation Commission, in coordination with the Secretary of Health and Human Resources, the Bureau of Insurance submits this Report of the Prior Authorization Metrics Reporting Work Group on behalf of the work group, pursuant to Chapters [58](#) and [68](#) of the 2025 Acts of Assembly.

While the Bureau of Insurance and the Health and Human Resources Secretariat staffed and facilitated the work group, this consensus report represents the perspectives solely of the work group.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

Table of Contents

Executive Summary	2
1. Introduction	3
2. Findings and Recommendations	4
A. Federal Developments	4
B. Implementation Readiness.....	5
C. Supporting Policies.....	6
Appendix A. Summary of Work Group Meetings	7
Appendix B. Work Group Resources and Interested Stakeholders	9
End Notes.....	10

Executive Summary

The third enactment clause of Chapters [58](#) and [68](#) of the 2025 Acts of Assembly directs the State Corporation Commission (Commission), in coordination with the Secretary of Health and Human Resources (SHHR), to convene a stakeholder work group to:

(i) monitor anticipated federal developments related to the implementation of (metrics reporting) requirements to make ... information pertaining to prior authorization for health care services¹ (publicly available) consistent with the provisions of [§ 38.2-3407.15:8](#) of the Code of Virginia (Code)...; (ii) assess industry progress and readiness to implement such requirements; and (iii) evaluate policies supporting the effective and efficient adoption of such requirements.

The work group sought to ensure consistent metrics reporting requirements in support of a unified and transparent prior authorization protocol across both public and private health insurance markets. To this end, it makes the following key findings and recommendations:

Key Findings

The work group finds that Virginia's prior authorization metrics reporting requirements in § 38.2-3407.15:8 of the Code, for carriers providing health care services in the private commercial market, promote a unified reporting process and mirror by reference those adopted at the federal level for impacted payers² providing medical items and services, as prescribed in 42 C.F.R §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c); and related regulations.

The work group is unaware of any major federal rules proposed or adopted that would build upon, add to, or subtract from the corresponding metrics reporting requirements delineated in the Virginia law. However, the Centers for Medicare and Medicaid Services (CMS) has since published a reporting template and overview for voluntary use by payers.

The work group finds that Virginia's private commercial health carriers appear ready and able to implement Virginia's reporting mandate as currently constituted. No specific challenges or impediments were identified by work group participants.

Key Recommendations

The work group recommends no changes to § 38.2-3407.15:8 of the Code related to reporting requirements.

The work group recommends that interested stakeholders continue to monitor federal activities related to prior authorization metrics in the event future revisions to the federal requirements warrant updates to Virginia's law.

1. Introduction

Effective January 1, 2027, subsection F of [§ 38.2-3407.15:8](#) of the Code requires each health carrier “to 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 CMS, including those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).” These include the following:

1. A list of all items and services that require prior authorization.
2. The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
3. The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
4. The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
5. The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
6. The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
7. The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
8. The average and median time that elapsed between the submission of a request and a determination by the ... plan, for standard prior authorizations, aggregated for all items and services.
9. The average and median time that elapsed between the submission of a request and a decision by the ... plan for expedited prior authorizations, aggregated for all items and services.

Subsection C of that same section of the Code also requires carriers to “make available through one central location on the carrier’s publicly accessible website or other electronic application, the list of services and codes for which prior authorization is required.”

The third enactment clause of Chapters [58](#) and [68](#) of the 2025 Acts of Assembly directs the Commission, in coordination with the SHHR, to convene a stakeholder work group to:

- (i) monitor anticipated federal developments related to the implementation of (metrics reporting) requirements to make ... information pertaining to prior authorization for health care services (publicly available) consistent with the provisions of [§ 38.2-3407.15:8](#) of the Code of Virginia (Code)... ; (ii) assess industry progress and readiness to implement such requirements; and (iii)

evaluate policies supporting the effective and efficient adoption of such requirements.

The work group must report its findings and recommendations to the chairs of the Senate Committees on Commerce and Labor and Education and Health; and chairs of the House of Delegates Committees on Labor and Commerce and Health and Human Services, by November 1, 2025. This report is submitted by the Commission on behalf of the work group whose perspectives it represents.

Statutorily named work group members include representatives of the Virginia Association of Health Plans, Medical Society of Virginia, and Virginia Hospital and Healthcare Association. The list of interested stakeholder organizations that participated in the work group is included in Appendix B.

Given the parallels between this work group³ and an existing multi-year electronic prior authorization (ePA) work group⁴ also staffed and facilitated by the Commission in coordination with the SHHR, participating stakeholders agreed to have the two meet concurrently as one, but issue separate reports for reasons of statutory compliance, efficiency, and continuity. This work group held five meetings between April and August 2025, with a summary of each included in Appendix A.

In fulfilling its statutory mandate, the work group sought to ensure consistent metrics reporting requirements in support of a unified and transparent prior authorization protocol across both public and private health insurance markets. The CMS mandate for a unified approach to prior authorization metrics reporting for government plan sponsors and payers is driving progress towards this end.

2. Findings and Recommendations

Based on presentations, research, and stakeholder input and discussions, the work group makes the following findings and recommendations.

A. Federal Developments

Findings

A1. On February 8, 2024, the CMS published its final rule on [“Advancing Interoperability and Improving Prior Authorization” \(CMS Rule 0057-F\)](#)⁵ – referred to herein as the “2024 Prior Authorization Rule.” This new rule took effect on April 8, 2024. It requires impacted payers to implement certain prior authorization metrics reporting requirements by January 1, 2026, and make the information publicly accessible by March 31, 2026, for the preceding calendar year, and then annually thereafter.⁶ These can be found in 42 C.F.R. §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).

A2. The work group is unaware of any major federal rules proposed or adopted that would build upon, add to, or subtract from the corresponding metrics reporting

requirements delineated in § 38.2-3407.15:8 of the Code. However, since adopting the 2024 Prior Authorization Rule, the CMS has published a prior authorization metrics reporting template and overview⁷ for voluntary use.⁸ The Virginia Department of Medical Assistance Services is in the process of developing one for the Virginia Medicaid program for use by managed care organizations. The CMS also has released metrics for Medicare fee-for-service plans as an example of the way in which payers can publish prior authorization and pre-claim review statistics.⁹

Recommendations

A1. The work group recommends that interested stakeholders continue to monitor federal activities related to prior authorization metrics in the event future revisions to the federal requirements necessitate corresponding updates to Virginia's metrics reporting requirements in § 38.2-3407.15:8 of the Code.

A2. The work group considered a proposal to expand the scope of prior authorization metrics reporting to include prescription drugs. While receptive to the proposal in concept, the work group ultimately decided it would be prudent to monitor federal developments in the drug space and defer further discussion until next year. The work group recognizes 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 work group's desire to tie any state requirements to those adopted at the federal level. Since this work group expires when it completes its mandate with the submission of this report, the work group recommends that such further consideration occur as part of the deliberations of the ePA work group and be reflected in revisions to that work group's charge in [Chapter 284](#) of the 2025 Acts of Assembly.

B. Implementation Readiness

Findings

B1. Virginia health plans appear ready and able to comply with the metrics reporting requirements as currently constituted. No specific challenges or impediments were raised during the work group meetings.

B2. According to a national survey¹⁰ conducted by the Workgroup for Electronic Data Interchange (WEDI) in January/February 2025 and released in April 2025 on the implementation of the 2024 Prior Authorization Rule, impacted payers reported progress in implementing the federal prior authorization metrics reporting requirements:

- 28% were between 75 and 100% complete;
- 32% were between 25 and 50% complete; and
- 25% had not yet started.

The WEDI is updating these results with a follow-up survey in late 2025, with plans for another survey later in 2026, to track progress in implementing the 2024 Prior Authorization Rule.¹¹ Although these numbers are not specific to payers providing private commercial coverage in Virginia, the work group finds these numbers are likely indicative of their readiness to implement Virginia's parallel reporting requirements since payers writing more than 80% of private commercial coverage in Virginia appear to write coverage in at least one jurisdiction countrywide that is subject to the federal requirements.¹²

B3. According to health plan representatives participating in the work group, the January 1, 2027, effective date in Virginia law, gives private commercial health plans sufficient time to implement the reporting requirements applicable to all health plans subject to this section of the Code. No impediments were cited by the work group.

Recommendations

B1. The work group recommends that Virginia move forward with the implementation of the metrics reporting requirements as provided in § 38.2-3407.15:8 of the Code. No statutory changes are suggested or requested prior to the January 1, 2027, implementation date in the absence of future changes in the federal reporting requirements.

C. Supporting Policies

Findings

C1. The work group finds that Virginia's prior authorization metrics reporting requirements in § 38.2-3407.15:8 of the Code, for carriers providing health care services in the private commercial market, promote a unified reporting process and mirror by reference those adopted at the federal level for impacted payers providing medical items and services as prescribed in 42 C.F.R. §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c), and related regulations.

Recommendations

C1. No revisions to state requirements or any additional policies are necessary to align Virginia's requirements with the federal requirements.

Appendix A. Summary of Work Group Meetings

The work group met five times between April and September 2025.

April 22

The work group held its initial meeting concurrent with the meeting of the ePA Work Group. It opened with remarks from Delegate Michelle Maldonado, the chief patron of Chapter 58 of the 2025 Acts of Assembly. Given the parallels between the membership and charge of this new work group and the existing multi-year ePA work group, the House patrons and work group members agreed to have the two meet concurrently as one work group but issue separate reports. Staff reviewed the work group's meeting schedule, charge and reporting requirement, membership, and suggestions for future presenters.

Substantively, the work group discussed possible mechanisms and timeframes for assessing industry progress and readiness to implement the metrics reporting requirements. The work group thought that the results in the recently released survey conducted by the WEDI as well as the Virginia Medicaid program's implementation experience to date would be helpful and suggested presentations from both.

May 21

The work group reviewed the prior authorization metrics reporting requirements designed to mirror those imposed by the 2024 Prior Authorization Rule at the federal level. It discussed how much, if any, new material there was to consider beyond the terms of the new Virginia law in § 38.2-3407.15:8 of the Code that would become effective on January 1, 2027. The work group made the following determinations:

- The data reporting requirements in § 38.2-3407.15:8 of the Code, as it would become effective on January 1, 2027, are consistent with and mirror federal data reporting and public accessibility requirements and no revisions to state requirements are necessary;
- Virginia health plans that are not otherwise subject to federal regulations nevertheless must comply with the reporting requirements in those sections of federal law cited in subsection F of § 38.2-3407.15:8 of the Code, as it would become effective on January 1, 2027;
- The January 1, 2027, effective date gives Virginia health plans sufficient time to implement the reporting requirements applicable to all health plans subject to this section of the Code; and
- Virginia health plans would be ready and able to implement these reporting requirements.

June 23

The work group received three presentations. The first, from the WEDI, reviewed key results and insights from its survey on the implementation of the 2024 Prior Authorization Rule, including those most directly related to prior authorization metrics reporting. The second, from CMS, provided an update on federal developments related to ePA and metrics reporting since adoption of the 2024 Prior Authorization Rule, as well as any pending proposals. The third, from Leavitt Partners, reviewed the prior authorization architecture in the 2024 Prior Authorization Rule and the interplay among the four application programming interfaces from a prior authorization perspective. They also discussed Health Level Seven's (HL7®) continuing work to advance implementation of medical ePA and the Fast Healthcare Interoperability Resources® (FHIR®) standard through the [Da Vinci](#) accelerator project, state-driven engagements such as the [One Utah Health Collaborative](#), and industry progress in responding to the implementation of the 2024 Prior Authorization Rule.

July 15

The work group briefly discussed whether any further discussion of or information concerning metrics reporting requirements was necessary to complete its report. While the general consensus was that nothing more was necessary, one health plan did recommend pushing the initial reporting date back one year. It was suggested the proponent work with stakeholders prior to the August meeting to see if consensus could be reached.

August 19

The work group reviewed the draft report and considered a proposal to extend the metrics reporting requirements to prescription drugs. While receptive to the proposal in concept, the work group believed it prudent for a variety of reasons to defer further consideration until next year as part of the deliberations of the ePA work group. It then agreed to provide a one-week exposure period for work group members to comment on the draft report and that if there were no substantive issues in controversy after exposure, staff would make any necessary non-substantive editorial changes and send it to work group members for final approval via email without the need for a final meeting. The report draft would then undergo the standard internal review at the Commission prior to submittal to the designated committee chairs in the General Assembly.

Appendix B. Work Group Resources and Interested Stakeholder Organizations

Federal Government Resources

Centers for Medicare and Medicaid Services

Virginia Government Resources

State Corporation Commission Bureau of Insurance
Virginia Department of Health Professions
Virginia Department of Medical Assistance Services
Virginia Department of Health
Virginia Health and Human Resources Secretariat

Interested Stakeholder Organizations

America's Health Insurance Plans (AHIP)
Arthritis Foundation
CareFirst BlueCross BlueShield
Elevance Health (Anthem)
Leavitt Partners
Medical Society of Virginia
National Council for Prescription Drug Programs
Pharmaceutical Care Management Association
Surescripts
Virginia Association of Health Plans
Virginia Dental Association
Virginia Health Information
Virginia Hospital & Healthcare Association
Virginia Pharmacy Association
Workgroup for Electronic Data Interchange (WEDI)

End Notes

¹ The work group charge in § 38.2-3407.15:8 of the Code of Virginia (effective January 1, 2027) uses the phrase “health care services” rather than the phrase “medical items and services” used in the Centers for Medicare and Medicaid Services (CMS) Rule 0057-F, herein referred to as the 2024 Prior Authorization Rule. “Health care services” is defined as having the same meaning as provided in § 38.2-3407.15 of the Code except that, as used in § 38.2-3407.15:8, “health care services” does not include drugs that are subject to the requirements of § 38.2-3407.15:2. Likewise, CMS Rule 0057-F does not include drugs.

² Under the CMS 2024 Prior Authorization Rule, “impacted payers” include Medicare Advantage organizations; managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans under contract with a state Medicaid agency; state Medicaid agencies; every state on behalf of its Children's Health Insurance Program; and qualified health plan (QHP) issuers offering a QHP on a federally facilitated exchange. Qualified Health Plans on state-based exchanges such as Virginia's are not subject to this requirement. However, CMS “encourage(s) . . . State-based Exchanges operating their own platform . . . to consider adopting similar requirements for (Qualified Health Plans) on their Exchanges.”

³ Chapters [58](#) and [68](#), Virginia Acts of Assembly – 2025 Session.

⁴ Chapter [284](#), Virginia Acts of Assembly – 2025 Session.

⁵ Centers for Medicare and Medicaid Services (CMS), “[Advancing Interoperability and Improving Prior Authorization \(CMS-0057-F\)](#),” 89 Fed. Reg. 8758 (February 8, 2024).

⁶ CMS, 89 Fed. Reg. 8761 (Feb. 8, 2024), <https://www.federalregister.gov/d/2024-00895/page-8761>.

⁷ CMS, “[Prior Authorization Metrics Reporting – Overview & Template](#).”

⁸ CMS, Presentation to the Prior Authorization Metrics Reporting Work Group, June 23, 2025.

⁹ CMS, “[Prior Authorization and Pre-Claim Review Program Stats for Fiscal Year 2023](#),” January 17, 2023.

¹⁰ Workgroup for Electronic Data Interchange (WEDI), “CMS Interoperability and Prior Authorization Final Rule Survey,” April 10, 2005.

¹¹ WEDI, “[CMS Interoperability and Prior Authorization Final Rule Survey](#),” April 10, 2005. (Access may require free registration.)

¹² Percentage derived by the Bureau of Insurance from information contained in the 2023 Accident & Health Policy Experience Exhibit and the Supplemental Health Care Exhibit. Interchange (WEDI), “CMS Interoperability and Prior Authorization Final Rule Survey,” April 10, 2005.

¹² WEDI, “[CMS Interoperability and Prior Authorization Final Rule Survey](#),” April 10, 2025. (Access may require free registration.)