Summary of Certain 2019 Virginia Insurance Law Amendments

The Virginia General Assembly has enacted amendments or additions to several portions of the Code of Virginia (the "Code") relating to insurance that go into effect July 1, 2019 (except as otherwise indicated). The following is a brief summary of some of the amendments that may be of interest.

General Changes:

- **Insurance Holding Companies; Supervision of Internationally Active Insurance Groups.** HB 1759 amends and reenacts §§ 38.2-1322 and 38.2-1333 and adds § 38.2-1332.2 to the Code. The changes authorize a designated state to act as a group-wide supervisor for an internationally active insurance group (IAIG). An IAIG is an insurance holding company group that has premiums written in at least three countries, has at least 10 percent of premiums written in foreign countries, and has total assets greater than $50 billion or total premiums greater than $10 billion. The measure enacts provisions of the National Association of Insurance Commissioners' revisions to the Model Insurance Holding Company System Regulatory Act.

- **Insurance Licensing, Biennial; Renewal for Individuals and Business Entities, etc.** SB 1222 amends and reenacts §§ 19.2-389, 38.2-1819, 38.2-1820, 38.2-1824, 38.2-1826, 38.2-1838, 38.2-1840, 38.2-1841, 38.2-1842, 38.2-1845.2, 38.2-1845.8, 38.2-1845.17, 38.2-1845.22, 38.2-1857.2, 38.2-1857.5, 38.2-1857.9, 38.2-1865.1, 38.2-1865.5, 38.2-1867, 38.2-1868.1, 38.2-1869, 38.2-1871, 38.2-1872, 38.2-1873, 38.2-1876, 38.2-1882, 38.2-1888, and 55-525.30 and adds §§ 38.2-1825.1 and 38.2-1857.4:1 to the Code. These amendments require the biennial renewal, for individuals and business entities, of licenses by insurance agents, consultants, public adjusters, surplus lines brokers, and viatical settlement brokers by a producer's year and month of birth. The measure also requires fingerprinting for the purpose of conducting state and federal criminal background checks on new resident applicants. The measure establishes fees for processing license renewal applications, requires proof of compliance with continuing education requirements, addresses reinstatement of licenses, and provides for waivers of certain requirements. The measure requires licensed persons to report changes in their name or address. The measure provides that the registration fee for settlement agents will be prescribed by the

Commission and that the Commission will retain the authority to enforce these provisions against any person who is under investigation for or charged with a violation. The measure also revises the timeline for completion of insurance continuing education courses to biennially, based on an insurance agent's year and month of birth. The measure modifies the membership of the insurance continuing education board and the criteria for selection by the State Corporation Commission of the same. **Effective January 1, 2021.**

Property & Casualty:

- **Fire Insurance Policies; Change in Amount of Coverage.** HB 1836 adds § 38.2-2108.1 to the Code and prohibits an insurer from increasing or decreasing the amount of fire insurance coverage, including fire insurance in combination with other coverage, on commercial property under a policy that has been in effect for at least 60 days unless the first named insured has consented in writing to such a change.

- **Motor Vehicle Insurance Policies; Foster Parents and Foster Child.** HB 1883 amends and reenacts §§ 38.2-2212 and 38.2-2213 of the Code to prohibit an insurer from refusing to issue or failing to renew a motor vehicle insurance policy solely because of the status of the applicant or policyholder, as applicable, as a foster care provider or a person in foster care.

- **Guaranteed Asset Protection Waivers; Establishes Requirements for Offering Waivers, etc.** HB 2109 adds §§ 38.2-6400 through 38.2-6407 to the Code, which establish requirements for offering guaranteed asset protection (GAP) waivers, which are agreements, entered into as a part of or addendum to a motor vehicle financing agreement, under which the creditor agrees for a separate charge to waive or cancel amounts due on the finance agreement if the financed motor vehicle is totally damaged or stolen. The measure requires the creditor to insure its GAP waiver obligations; prohibits a creditor from conditioning an extension or term of credit on the purchase of a GAP waiver; requires a GAP waiver to include disclosures regarding the cancellation of the GAP waiver during a free look period; and establishes requirements and restrictions for the cancellation of GAP waivers, including refund provisions. The measure provides that GAP waivers are not insurance and are exempt from Virginia's insurance laws.

- **Insurance; Use of Credit Rating.** HB 2230 amends and reenacts §§ 38.2-2126 and 38.2-2234 of the Code to clarify what constitutes adverse action in the use of credit in the rating and underwriting of homeowners and private passenger automobile insurance policies. An insurer is required to notify the applicant or insured when an insurer takes adverse action based on credit information. The measure conforms the definition of adverse action to the U.S. Supreme Court's decision in *Safeco Insurance Company v. Burr*, in which it held that

an adverse action has occurred only when the use of credit information puts the applicant or insured in a worse position than if credit had not been considered.

- **Uninsured Motorist Insurance Coverage; Settlement and Release.** SB 1293 amends and reenacts § 38.2-2206 of the Code to provide that any release executed as a result of a liability insurer settling a personal injury claim with an underinsured claimant for the available limits of the liability insurer's coverage shall not operate to release any parties other than the liability insurer and the underinsured motorist. The change clarifies that neither a duty to defend nor an attorney-client relationship is created between the underinsured motorist and counsel for the underinsured motorist benefits insurer without the express intent and agreement of the underinsured motorist. The measure modifies the language in the written notice that is required to be provided to the underinsured motorist upon settlement to further clarify that no attorney-client relationship or duty to defend is created between the underinsured motorist and the underinsured motorist benefits insurer as a result of the settlement and release. By sending the notice and release to the underinsured motorist's last known address by certified mail, the liability insurer satisfies the requirement of having the underinsured motorist sign the release and initial the notice.

- **Public Adjusters; Regulation.** SB 1415 amends and reenacts §§ 38.2-1845.1, 38.2-1845.12, 38.2-1845.13, and 38.2-1846.16 of the Code to provide that public adjusting includes soliciting an insured. The measure expands the list of activities in which any person other than a licensed public adjuster is prohibited from engaging to include (i) preparing, completing, or filing an insurance claim on behalf of an insured; (ii) aiding or acting on behalf of an insured in negotiating for or effecting the settlement of a claim for loss or damage covered by an insurance contract; (iii) advertising for employment as a public adjuster; or (iv) soliciting, investigating, or adjusting a claim on behalf of a public adjuster or an insured. The measure provides that an insured may void a contract he may have signed with a person who is not licensed as a public adjuster. The measure also requires that (a) the account into which funds received by a public adjuster on behalf of an insured toward the settlement of a claim be a noninterest-bearing account and (b) the public adjuster keep accurate and itemized records of the funds deposited into the account, which funds are required to be held separately from other funds and be reasonably ascertainable from the books of accounts and records of the public adjuster.

- **Travel insurance.** HB 2186 and SB 1565 amend and reenact §§ 38.2-126, 38.2-1187, and 38.2-1888 of the Code and amends the Code by adding §§ 38.2-1888.1 through 38.2-1885.5 and 58.1-2501.1, by establishing procedures and requirements for travel protection plans and travel administrators. The legislation establishes travel insurance as an inland marine line of insurance sold by property and casualty insurance agents. The legislation (i) prohibits any person from acting as a limited lines travel insurance agent unless properly licensed, (ii) prohibits any person from acting as a travel retailer unless properly registered,

and (iii) authorizes the State Corporation Commission to take enforcement actions, including suspending, revoking, or terminating a license. The legislation establishes a premium tax on travel insurance premiums paid by residents of the Commonwealth and establishes acceptable practices for the sale and advertising of travel insurance. The legislation to travel insurance policies purchased on or after July 1, 2019.

Life & Health:

- **Health Carriers; Services Provided by Nurse Practitioners.** HB 1640 amends and reenacts §§ 38.2-3408 and 38.2-4221 of the Code. The changes require health insurers and health services plan providers whose policies or contracts cover services that may be legally performed by licensed nurse practitioners to provide equal coverage for such services when rendered by a licensed nurse practitioner. The measure also contains an enactment that exempts it from the requirement that the Health Insurance Reform Commission review any legislative measure containing a mandated health insurance benefit or provider. **Effective October 1, 2019.**

- **Dental Services; Contracts Between Carriers and Providers, PPO Network Arrangement, etc.** HB 1682 amends and reenacts § 38.2-4509 and adds § 38.2-3407.17:1 to the Code. The measure establishes limits on the ability of a health carrier or third-party administrator to sell or otherwise grant access, as provided in a dentist's or oral surgeon's provider contract, to a third-party carrier. It also provides that such access may be granted only if it is expressly permitted by the provider contract and notice is given to the affected participating providers. The contracting entity or carrier is required to inform participating providers, upon request, which network plans have been granted access to the contract by the contracting entity.

- **Accident and Sickness Insurance; Step Therapy Protocols.** HB 2126 adds § 38.2-3407.9:05 to the Code and requires carriers issuing health benefit plans that develop step therapy protocols for a health benefit plan to ensure that those step therapy protocols are (i) developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members; (ii) based on peer-reviewed research and medical practice; and (iii) continually updated based on a review of new evidence, research, and newly developed treatments. The measure requires that when coverage of a prescription drug for the treatment of a medical condition is restricted for use by a carrier or utilization review organization through the use of a step therapy protocol, the patient and prescribing provider have access to a clear, readily accessible, and convenient process to request a step therapy exception. The measure establishes conditions under which a request for a step therapy exception shall be granted. The provisions of the measure shall apply to any health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2020. **Effective January 1, 2020.**

- **Rates for Individual and Certain Group Health Benefit Plans; Minimum Loss Ratios.** HB 2345 amends and reenacts § 38.2-316.1 of the Code. The changes codify certain provisions that currently are set out in regulations adopted by the State Corporation Commission pertaining to the establishment of minimum loss rations to assure that the benefits provided by accident and sickness insurance policies are or are likely to be reasonable in relation to the premiums charged. The measure authorizes the Commission, upon finding that a premium rate filed will not meet the originally filed and approved loss ratio, to require appropriate rate adjustments, premium refunds, or premium credits as necessary for the coverage to conform with established minimum loss ratio standards.

- **Cancer Patients; Expedited Review of Adverse Coverage Determinations.** HB 1915/SB 1161 amends and reenacts §§ 38.2-3559 through 38.2-3562 of the Code to provide that a covered person shall not be required to have exhausted his health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat his cancer. The measure provides that a covered person may request an expedited external review if the adverse determination relates to the treatment of a cancer of the covered person. The measure requires health carriers' notices of the right to an external review to notify covered persons of this provision. **Effective April 3, 2019.**

- **Pharmacies; Freedom of Choice.** SB 1197 amends and reenacts 38.2-3407.7 of the Code to require carriers that provide exclusive provider policies and contracts to allow consumers freedom of choice for pharmacy benefits. This requirement currently applies to health insurers, health services plans, and health maintenance organizations in Virginia.

- **Telemedicine Services; Payment and Coverage of Services.** SB 1221/HB 1970 amends and reenacts §§ 32.1-325 and 38.2-3418.16 of the Code. The changes require insurers, corporations, or health maintenance organizations to cover medically necessary remote patient monitoring services as part of their coverage of telemedicine services to the full extent that these services are available. The measure defines remote patient monitoring services as the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload. It also requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services.

- **Health Insurance; Small Employers.** SB 1475/HB 2719 amends and reenacts § 38.2-3431 of the Code and revises the definition of "small employer" for purposes of group

health insurance policies to provide that an individual who performs any service for remuneration under a contract of hire for (i) a corporation in which he is a shareholder or an immediate family member of a shareholder, or (ii) a limited liability company in which he is a member, regardless of the number of members of the limited liability company, shall be deemed to be an employee of the corporation or the limited liability company. The measure provides that a health insurance issuer shall not be required to issue more than one group health plan for each employer identification number issued by the Internal Revenue Service for a business entity, without regard to the number of shareholders or members of such business entity.

- **Health Plans; Calculation of Enrollee's Contribution.** SB 1596/HB 2515 amends and reenacts §§ 38.2-4214 and 38.2-4319 and adds § 38.2-3407.20 to the Code. The changes require any carrier issuing a health plan in the Commonwealth to count any payments made by another person on the enrollee's behalf, as well as payments made by the enrollee, when calculating the enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under the carrier's health plan.

- **Health Insurance; Carrier Business Practices, Authorization of Health Care Services.** SB 1607 amends and reenacts §§ 38.2-3407.15 and 38.2-3407.15:2 of the Code. The measure provides that if a carrier has previously authorized an invasive or surgical 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 it is appropriately coded consistent with the procedure actually performed, the additional procedures were not investigative in nature, and the additional procedure was compliant with a carrier's post-service claims process. The measure requires any provider contract between a carrier and a participating health care provider to contain certain specific provisions addressing how carriers interact with prior authorization requests. The measure requires that no prior authorization is 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. The measure clarifies that the 24-hour period during which a carrier is required to communicate to a prescriber if an urgent prior authorization request submitted telephonically or in an alternate method directed by the carrier has been approved, denied, or requires supplementation includes weekend hours. The measure provides that a carrier shall not be required to pay a claim if the carrier has previously authorized health care service if, during the post-service claims process, it is determined that the claim was submitted fraudulently.

- **Health Care Shared Savings; Incentive Programs.** HB 2639/SB 1611 amends and reenacts §§ 38.2-4214, 38.2-4319, and 54.1-2910.01 and adds §§ 38.2-3461 through 38.2-

3464 to the Code. The changes require health carriers to establish a comparable health care service incentive program under which savings are shared with a covered person who elects to receive a covered comparable health care service from a lower-cost provider. Incentive payments are not required for savings of $25 or less. Health carriers must comply with transparency requirements beginning with health benefit plans offered or renewed on or after July 1, 2020. Programs are required to be approved by the Commissioner of Insurance.

- **Health Insurance; Credentialing, Mental Health Professionals.** SB 1685 amends and reenacts § 38.2-3407.10:1 and adds § 38.2-3407.10:2 of the Code to require health insurers and other carriers that credential the mental health professionals in their provider networks to establish reasonable protocols and procedures for reimbursing a mental health professional who has submitted a completed credentialing application to a carrier, after being credentialed by the carrier, for mental health services provided to covered persons during the period in which the applicant's completed credentialing application is pending. The measure requires health maintenance organizations that issue Medicaid coverage to provide reimbursement to physicians and mental health professionals during the credentialing process. Under current law, Medicare Advantage plans and Medicaid plans are excluded from such requirement. The measure provides that health insurers that credential mental health professionals in their network may establish reasonable protocols and procedures for credentialing private mental health agencies. The changes establish minimum standards that must be maintained by credentialed private mental health agencies.

- **Health Insurance; Coverage for Autism Spectrum Disorder.** HB 2577/SB 1693 amends and reenacts § 38.2-3418.17 of the Code to require health insurers, health care subscription plans, and health maintenance organizations to provide coverage for the diagnosis and treatment of autism spectrum disorder in individuals of any age. Currently, such coverage is required to be provided for individuals from age two through age 10. The provision applies with respect to insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2020.

- **Accident and Sickness Insurance; Restrictions Relating to Premium Rates.** HB 2770/SB 1734 amends and reenacts § 38.2-3447 of the Code to require a rate filing by a health carrier that proposes area rate factors in the individual or small group market that exceed the weighted average of the proposed area rate factors among all rating areas by more than 15 percent to include, in publicly available and unredacted form, a comparison of the area rate factor for individual and small group plans that utilize the same provider network and provider reimbursement levels of the health benefit plans that are subject to the filing. In addition, to the extent that the health carrier is deriving any area rate factor from experience data, the measure requires the health carrier to provide additional

information, including aggregated incurred claims for any provider exceeding 30 percent of total claims for the rating area that market. The measure requires the State Corporation Commission to hold a public hearing before approving such proposed rates. The measure also bars the Commission from approving such a proposed rate filing if (i) a variance in area rate factors, indexed to the same rating region for both the individual and small group markets, of 15 percent or more exists between health benefit plans a carrier intends to offer in the individual market and health benefit plans intended to be offered in the small group market, when those plans utilize the same provider networks and reimbursement levels; and (ii) the methodologies used to calculate the area rate factors are different between the two markets. The measure provides that beginning for plan year 2020, a health carrier with an approved rate filing that contains at least one area rate factor that exceeds by more than 25 percent the weighted average of the area rate factors among all rating areas in a market in which the health carrier offers individual or small group health insurance coverage shall file with the Commission for each calendar quarter during that plan year a report that provides, for each rating area within the market in which the health carrier operates, the plan's enrollment, total premiums, allowed claims, incurred claims excluding anticipated or, if available, actual risk adjustment payments or receipts, incurred claims including anticipated or, if available, actual risk adjustment payments or receipts, loss ratio, and aggregate claims, for each provider exceeding 25 percent of total claims for that rating area. The measure requires the health carrier to make each such quarterly report publicly available, without redaction, not later than 45 days after the end of the calendar quarter.

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Please note this is just a summary of certain legislative changes. It is not a complete list or interpretation of the insurance related legislative amendments in Virginia in 2019. If you have any questions or would like additional information, please contact Scott Sorkin or Richard Bland at ssorkin@blandsorkin.com or rbland@blandsorkin.com.