Summary of Certain 2020 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, 2020 (except as otherwise indicated). The following is a brief summary of some of the amendments that may be of interest.

General Changes:

- **Insurance data security; required programs and notifications.** HB 1334 amend and reenacts sections like §§ 38.2-100, 38.2-600, 38.2-601, 38.2-602, 38.2-612.1, 38.2-612.2, 38.2-613, 38.2-614 through 38.2-618, 38.2-4214, 38.2-4319, 38.2-4408, and 38.2-4509 of the Code; to amend the Code by adding in Chapter 6 of Title 38.2 an article numbered 2, consisting of sections numbered 38.2-621 through 38.2-629; and to repeal §§ 38.2-613.2 and 38.2-620 of the Code. These amendments establish standards for insurance data security and for the investigation of a cybersecurity event and the notification to the Commissioner of Insurance and affected consumers of a cybersecurity event. The bill requires insurers to develop, implement, and maintain a comprehensive written information security program based on an assessment of its risk and that contains administrative, technical, and physical safeguards for the protection of nonpublic information and its information system. The bill requires investigation of potential cybersecurity events and prescribes standards for such investigations. The bill requires that the notification of the occurrence of a cybersecurity event provided by an insurer or other entity to the Commissioner and affected consumers to include certain information prescribed by the bill. The bill requires the Commissioner to adopt rules and regulations regarding data security and authorizes the Commissioner to investigate potential violations.

- **Insurance licensing and registration renewal.** SB 233 amends and reenacts §§ 38.2-1845.2, as it is currently effective, 38.2-1845.8, as it is currently effective, 38.2-1845.9, as it is currently effective, 38.2-1888, as it shall become effective, and 55.1-1014, as it shall become effective, of the Code. These amendments make changes related to renewal of insurance agents' licensure and registration. In 2019, legislation was enacted that becomes effective January 1, 2021, to change the licensing and registration renewal cycles for agents, public adjusters, and others to a new cycle based on both month and year, with

biennial renewal. The bill removes references in the current law to biennial renewal, removes a requirement in the law as it will become effective that limited lines agents renew their licenses before May 1, 2021, and adds a requirement in the law as it will become effective that certain settlement agents renew their registrations before May 1, 2021.

- **Life and annuities agents; report on examination passage rate.** SB 165 amends and reenacts § 38.2-1815 of the Code. The amendment eliminates the requirement that the State Corporation Commission provide an annual report to the General Assembly on the licensure exam passage rate of candidates for licensure as a life and annuities agent.

- **Peer-to-peer vehicle sharing platforms.** SB 735 amends and reenacts sections like § 38.2-2204 of the Code. These amendments establish insurance, taxation, recordkeeping, disclosure, and safety recall requirements for peer-to-peer vehicle sharing platforms, defined in the bill. **Effective October 1, 2020.**

- **Legal services plans.** HB 1240 amends and reenacts sections like §§ 38.2-316, 38.2-4402.1, and 38.2-4410 of the Code and amends the Code by adding a section numbered 38.2-4410.1. These amendments authorize legal services organizations to provide to the Virginia Department of Agriculture and Consumer Services any registration information or fees on behalf of their legal services plan sellers. Currently, sellers are required to register with the Department individually. The measure also (i) allows legal services plans to be written in Virginia by a foreign corporation that is licensed as an insurer in its state of domicile and authorized to write legal services plans under the laws of any state; (ii) authorizes a foreign insurer issuing legal services plans to file financial statements with the State Corporation Commission using certain alternative forms; (iii) allows a legal services organization to use policy forms without prior approval of the Commission if it has filed an informational filing and written notice of its intent to use the form; (iv) allows legal services organizations to exclude the management discussion and analysis sections of their financial statements filed with the Commission; and (v) provides that the Commission may investigate or examine a legal services organization as it deems necessary.

- **Gender-neutral terms; prohibitions on same-sex marriage and civil unions removed from Code; certain gender-specific crimes; penalty.** HB 623 amends and reenacts various provisions of the code including §§ 38.2-302, 38.2-2204, 38.2-2212, and 38.2-4019. These amendments replace the terms "husband" and "wife," as well as related terms, with gender-neutral terms throughout the Code to comport with the United States Supreme Court decision in Obergefell v. Hodges, 576 U.S. 644 (June 26, 2015).

- **Prohibited discrimination; sexual orientation and gender identity.** HB 1049 amends and reenacts various parts of the code including §§ 38.2-508.2, 38.2-2114, 38.2-2115, 38.2-2212, 38.2-2213, and 38.2-3407.10. These amendments prohibit discrimination in insurance and other areas, including employment, public accommodation, public

contracting, apprenticeship programs, housing, banking, and insurance on the basis of sexual orientation or gender identity. The bill also adds discrimination based on sexual orientation or gender identity to the list of unlawful discriminatory housing practices. The bill contains technical amendments.

Property & Casualty:

- **Uninsured and underinsured motorist insurance policies; bad faith.** SB 27 amends and reenacts sections like § 38.2-2206 of the Code. These amendments provide that if an insurance company denies, refuses, or fails to pay its insured, or refuses a reasonable settlement demand within the policy's coverage limits, for a claim for uninsured or underinsured motorist benefits within a reasonable time after being presented with a demand for such benefits and it is subsequently found that such denial, refusal, or failure was not in good faith, then the insurance company shall be liable to the insured for the full amount of the judgment and reasonable attorney fees, expenses, and interest from the date the initial settlement demand was presented to the insurance company.

- **Peer-to-peer vehicle sharing platforms; regulation; insurance; taxation**. HB 891 amends and reenacts sections like § 38.2-1800 of the Code. These amendments establish taxation, insurance coverage, sale of insurance, disclosure, safety recall, airport operation, and recordkeeping requirements for peer-to-peer vehicle sharing platforms, as defined in the bill.

- **Accident airtrip insurance; vending machine sales.** SB 164 repeals § 38.2-1807 of the Code. This amendment repeals the authorization for insurers to issue policies of accident airtrip insurance by means of mechanical vending machines in public airports.

Life & Health:

- **Virginia Health Benefit Exchange.** HB 1428/SB 732 amends and reenacts like §§ 38.2-326, 38.2-3455, 38.2-3456, 38.2-3457, 38.2-3459, 38.2-3460, 38.2-4214, 38.2-4319, and 38.2-4509 of the Code; to amend the Code by adding in Title 38.2 a chapter numbered 65, consisting of sections numbered 38.2-6500 through 38.2-6517; and to repeal the second enactment of Chapter 670 and the second enactment of Chapter 679 of the Acts of Assembly of 2013. These amendments Creates the Virginia Health Benefit Exchange, which will be established and operated by a new division within the State Corporation Commission (SCC). The Exchange shall facilitate the purchase and sale of qualified health plans and qualified dental plans to qualified individuals and qualified employers. The Exchange shall make qualified plans available to qualified individuals and qualified employers by July 1, 2023, unless the SCC postpones this date. The measure authorizes the SCC to review and approve accident and sickness insurance premium rates applicable

to health benefit plans in the individual and small group markets and health benefit plans providing health insurance coverage in the individual market through certain non-employer group plans. The Exchange will be funded by an assessment on health insurers, which is limited to three percent of total monthly premiums, except the SCC may, after a public hearing, adjust the rate as necessary to ensure the Exchange is fully funded. A health plan will not be required to cover any state-mandated health benefit if federal law does not require it to be covered as part of the essential benefits package. The essential health benefits are items and services included in the benchmark health insurance plan, which is the largest plan in the largest product in the Commonwealth's small group market as supplemented in order to provide coverage for the items and services within the statutory essential health benefits categories. The SCC may contract with other eligible entities and enter into memoranda of understanding with other agencies of the Commonwealth to carry out any of the functions of the Exchange, including agreements with other states or federal agencies to perform joint administrative functions. Such contracts are not subject to the Virginia Public Procurement Act (§ 2.2-4300 et seq.). The measure repeals a provision enacted in 2013 that prohibits an agent, employee, officer, or agency of the Commonwealth from taking any action to establish a health benefit exchange. The measure requires the Department of Taxation to include on the appropriate individual tax return forms a checkoff box or similar mechanism for indicating whether the individual, or spouse in the case of a married taxpayer filing jointly, or any dependent of the individual (i) is an uninsured individual at the time the return is filed and (ii) voluntarily consents to the Department of Taxation providing the individual's tax information to the Department of Medical Assistance Services for purposes of affirming that the individual, the individual's spouse, or any dependent of the individual meets the income eligibility for medical assistance. Finally, the measure requires the Secretary of Health and Human Resources to convene a work group that includes representatives from the SCC, the Department of Medical Assistance Services, the Department of Social Services, and the Department of Taxation and a consumer advocate to develop systems, policies, and practices to leverage state income tax returns to facilitate the enrollment of eligible individuals in insurance affordability programs through the Virginia Health Benefit Exchange established in this measure. The Secretary shall report the work group's recommendations to the Governor and the General Assembly by September 15, 2020.

- **Health insurance; payment to out-of-network providers.** HB 1251/SB 172 amends and reenacts sections like §§ 38.2-3438 and 38.2-3445 of the Code, adds sections numbered 38.2-3445.01 through 38.2-3445.07, and repeals § 38.2-3445.1 of the Code. These amendments provide that when an enrollee receives emergency services from an out-of-network health care provider or receives out-of-network surgical or ancillary services at an in-network facility, the enrollee is not required to pay the out-of-network provider any amount other than the applicable cost-sharing requirement and such cost-sharing requirement cannot exceed the cost-sharing requirement that would apply if the services

were provided in-network. The measure also provides that the health carrier's required payment to the out-of-network provider of the services is a commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area. If such provider disputes the amount to be paid by the health carrier, the measure requires the provider and the health carrier to make a good faith effort to reach a resolution on the amount of the reimbursement. If the health carrier and the provider do not agree to a commercially reasonable payment and either party wants to take further action to resolve the dispute, then the measure requires the dispute will be resolved by arbitration. The measure establishes a framework for arbitration of such disputes that includes (i) a timeline for the proceedings, (ii) a method for choosing an arbitrator, (iii) required and optional factors for the arbitrator to consider, (iv) non-disclosure agreements, (v) reporting requirements, and (vi) an appeals process for appeals on certain procedural grounds. The measure requires the State Corporation Commission to contract with Virginia Health Information (VHI) to establish a data set and business protocols to provide health carriers, providers, and arbitrators with data to assist in determining commercially reasonable payments and resolving disputes. The measure requires the Commission, in consultation with health carriers, providers, and consumers, to develop standard language for a notice of consumer rights regarding balance billing. The measure authorizes the Commission, the Board of Medicine, and the Commissioner of Health to levy fines and take action against a health carrier, health care practitioner, or medical care facility, respectively, for a pattern of violations of the prohibition against balance billing. Additionally, the measure prohibits a carrier or provider from initiating arbitration with such frequency as to indicate a general business practice. The measure provides that such provisions do not apply to an entity that provides or administers self-insured or self-funded plans; however, such entities may elect to be subject such provisions. The measure authorizes the Commission to adopt rules and regulations governing the arbitration process. This bill incorporates HB 58, HB 189, HB 901, HB 1494, and HB 1546 and is identical to SB 172. **The measure has a delayed effective date of January 1, 2021.**

- **Health benefit plans; enrollment by pregnant individuals.** HB 39 amends and reenacts § 38.2-3448 of the Code. This amendment requires health carriers to allow pregnant individuals to enroll in a health benefit plan at any time after the commencement of the pregnancy, with the pregnant individual's coverage being effective as of the first of the month in which the individual receives certification of the pregnancy. The measure applies to such agreements that are entered into, amended, extended, or renewed on or after January 1, 2021.

- **Health carriers; licensed athletic trainers.** HB 59 amends and reenacts §§ 38.2-3408 and 38.2-4221 of the Code. These amendments require health insurers and health service plan providers whose policies or contracts cover services that may be legally performed by a

licensed athletic trainer to provide equal coverage for such services when rendered by a licensed athletic trainer.

- **Health insurance; cost-sharing payments for prescription insulin drugs.** HB 66 amends the Code by adding a section numbered 38.2-3407.15:5. This amendment prohibits health insurance companies and other carriers from setting an amount exceeding $50 per 30-day supply that a covered person is required to pay at the point of sale in order to receive a covered prescription insulin drug. The measure also prohibits a provider contract between a carrier or its pharmacy benefits manager and a pharmacy from containing a provision (i) authorizing the carrier's pharmacy benefits manager or the pharmacy to charge, (ii) requiring the pharmacy to collect, or (iii) requiring a covered person to make a cost-sharing payment for a covered prescription insulin drug in an amount that exceeds such limitation. This bill incorporates HB 1403.

- **Reinsurance credits; conforms Virginia's law regarding credits to insurers for reinsurance, etc.** HB 154 amends and reenacts §§ 38.2-1316.1, 38.2-1316.2, 38.2-1316.4, and 38.2-1316.7 of the Code. These amendments conform Virginia's law regarding credits to insurers for reinsurance ceded to approved assuming insurers to the provisions of the Credit for Reinsurance Model Law of the National Association of Insurance Commissioners. The bill eliminates the reinsurance collateral requirements for assuming insurers that are domiciled in or have their head office in a reciprocal jurisdiction, which is defined in the bill. Under the bill, such assuming insurers are required to maintain a minimum capital and surplus, maintain a minimal solvency or capital ratio, as applicable, and provide notice to the State Corporation Commission in the event of noncompliance of any requirements. The bill requires the Commission to create and publish a list of reciprocal jurisdictions and assuming insurers.

- **Health insurance; authorization of drug prescribed by psychiatrist.** HB 348 amends and reenacts § 38.2-3407.15:2 of the Code. This amendment requires that any provider contract between a carrier and a participating health care provider with prescriptive authority, or its contracting agent, provide that no prior authorization is required for any drug prescribed by a psychiatrist, if (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.

- **Health insurance; coverage for donated human breast milk.** HB 442 amends and reenacts § 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18. This amendment requires health insurers, corporations providing health care coverage subscription contracts, and health maintenance organizations to provide coverage for expenses incurred in the provision of pasteurized donated human breast milk. The requirement applies if the covered person is an infant under the age of six months, the milk is obtained from a human milk bank that meets quality guidelines established by the

Department of Health, and a licensed medical practitioner has issued an order for an infant who satisfies certain criteria. The measure applies to policies, contracts, and plans delivered, issued for delivery, or renewed on or after January 1, 2021.

- **Health insurance; coverage for prosthetic devices.** HB 503 amends and reenacts sections like § 38.2-3418.15:1, and repeals § 38.2-3418.15 of the Code. These amendments require health insurers, corporations providing health care coverage subscription contracts, health maintenance organizations, and the Commonwealth's Medicaid program to provide coverage for prosthetic devices, including myoelectric, biomechanical, or microprocessor-controlled prosthetic devices that have a Medicare code. The measure repeals the existing requirement that coverage for prosthetic devices be offered and made available. **The measure has a delayed effective date of January 1, 2021**.

- **Reproductive health services; health benefit plans to cover the costs of specified services, etc.** HB 526 amends and reenacts §§ 38.2-3407.5:1 and 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18. The amendments require health benefit plans to cover the costs of specified health care services, drugs, devices, products, and procedures related to reproductive health, including (i) well-woman preventive visits; (ii) counseling for sexually transmitted infections; (iii) screening for certain conditions; (iv) folic acid supplements; (v) breastfeeding support, counseling, and supplies; (vi) breast cancer chemoprevention counseling; (vii) contraceptive drugs, devices, or products; (viii) voluntary sterilization; and (ix) any additional preventive services for women that must be covered without cost sharing under federal law as of January 1, 2019. The mandated coverage does not include abortion services other than when performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when the pregnancy is the result of an alleged act of rape or incest. The measure provides an exemption for plans sold to religious employers. Carriers are prohibited from excluding a covered person from participating in, being denied the benefits of, or otherwise being subjected to discrimination in the coverage of or payment for reproductive health services, and a violation constitutes an unfair trade practice. The health benefit plan requirements become effective when a plan is delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made.

- **Prescribing of Schedule VI controlled substances; telemedicine; store-and-forward technologies.** HB 546 amends and reenacts sections like § 38.2-3418.16 of the Code. The amendments provide that electronic technology or media used for telemedicine services includes store-and-forward technologies and that, used in the context of prescribing Schedule VI controlled substances through telemedicine services, "store-and-forward technologies" means technologies that allow for the electronic transmission of medical

information, including images, documents, or health histories, through a secure communications system.

- **Health insurance; coverage for mammograms.** HB 579 amends and reenacts § 38.2-3418.1 of the Code. The amendment requires health insurers, on and after January 1, 2021, to provide coverage for low-dose screening mammograms at rates that are more frequent than is currently required if the covered individual has a family history of breast cancer. If the individual has a family history of breast cancer, the bill requires coverage for annual mammograms from age 30 through 49 and biannual mammograms starting at age 50. However, the age at which such coverage of annual mammograms starts shall be younger than 30 if the covered individual's mother was diagnosed with breast cancer at an age earlier than 40, in which event coverage starts during the year that the individual attains an age that is 10 years younger than the age of the individual's mother at the time of her diagnosis.

- **Health insurance; amino acid-based elemental formula.** HB 612 amends and reenacts § 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18. These changes require health insurers, health care subscription plans, and health maintenance organizations whose policy, contract, or plan includes coverage for medicines to cover amino acid-based elemental formula for the treatment of specified diseases or disorders.

- **Health insurance; coverage for diabetes.** HB 645 amends and reenacts § 38.2-3418.10 of the Code. The amendment requires health insurers, health care subscription plans, and health maintenance organizations to include coverage for insulin, certain equipment, certain supplies, regular foot care and eye care exams, and up to three in-person outpatient self-management training and education visits upon an individual's initial diagnosis of diabetes and up to two such visits upon a significant change in an individual's condition. The bill provides greater specificity than the current law requiring coverage for equipment, supplies, and self-management training and education visits. The bill also provides that benefits or services required for the treatment of diabetes is exempt from any deductible. The provisions apply to any insurance policy, contract, or plan delivered, issued for delivery, reissued, or extended on and after January 1, 2021, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

- **Health insurance; coverage for fertility preservation procedures for cancer patients.** HB 776 amends and reenacts § 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18. These changes require health insurance policies, subscription contracts, and health care plans to provide coverage for standard fertility preservation procedures that are medically necessary to preserve the fertility of a covered individual due to the covered individual's receiving cancer treatment that may directly or indirectly cause iatrogenic infertility.

- **Health insurance; credentialing; health care providers.** HB 822 amends and reenacts § 38.2-3407.10:1 of the Code. This amendment requires health insurers and other carriers that credential certain health professionals in their provider networks to establish reasonable protocols and procedures for reimbursing such a professional who has submitted a completed credentialing application to a carrier, within 30 days of being credentialed by the carrier, for services provided to covered persons during the period in which the applicant's completed credentialing application is pending. The bill makes this requirement applicable to a person, corporation, facility, or institution licensed by the Commonwealth under Title 32.1 (Health) or Title 54.1 (Professions and Occupations) to provide health care or professional health-related services on a fee basis. Such a requirement exists in current law for participating physicians and participating mental health professionals but without a time limit for reimbursement. The bill applies the 30-day limit to such participating physicians and participating mental health professionals.

- **Prescription drug price transparency.** HB 876 amends the Code by adding things like § 38.2-3407.15:5. These changes require every health carrier, pharmacy benefits manager, wholesale drug distributer, and drug manufacturer to report information about prescription drug prices and related information to the Department of Health and requires the Department to make such information available on its website.

- **Preventive services; coverage for outpatient mental health screenings or visits.** HB 1036 amends and reenacts §§ 38.2-3438 and 38.2-3442 of the Code. These amendments require a health carrier to provide coverage as a preventive service for at least six annual therapy or counseling outpatient screenings or visits with a licensed mental health professional for the early detection or prevention of mental illness. Health carriers are prohibited from imposing any cost-sharing requirements for mandated preventive services.

- **Health insurance; short-term limited-duration medical plans.** HB 1037/SB 404 amends the Code by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.21. This amendment prohibits carriers from issuing in the Commonwealth, on or after July 1, 2021, any short-term limited-duration medical plan with a duration that exceeds three months or that can be renewed or extended beyond six months, or if the plan's issuance would result in a covered person being covered by a short-term limited-duration medical plan for more than six months in any 12-month period. The bill prohibits a carrier from issuing a short-term limited-duration medical plan during an annual open enrollment period. **Effective July 1, 2021.**

- **Health insurance; clinical nurse specialists.** HB 1057 amends and reenacts sections like §§ 38.2-3408, 38.2-3412.1, and 38.2-4221 of the Code. These amendments prohibit health insurers and health service plan providers whose policies or contracts cover services that may be legally performed by a licensed clinical nurse specialist from denying reimbursement because the service is rendered by a licensed clinical nurse specialist. The

measure removes the existing limitation that requires such reimbursement only to licensed clinical nurse specialists who render mental health services.

- **High deductible health plans; funding deductibles through health savings accounts.** HB 1087 amends and reenacts sections like § 38.2-5602.1 of the Code. These amendments require each employer sponsoring a high deductible health plan for its employees annually to fund the health savings account associated with the plan in an amount that is not less than the annual deductible amount under the plan. A similar requirement is imposed with regard to high deductible health plans offered to state employees under the state employee health insurance program.

- **Health benefit plans; special exception.** HB 1141 amends and reenacts § 38.2-3454.1 of the Code. This amendment eliminates provisions of the Code authorizing health carriers to sell, issue, or offer for sale any health benefit plan that would otherwise not be permitted to be sold, issued, or offered for sale due to conflict with the requirements of the federal Patient Protection and Affordable Care Act (PPACA), to the extent that the requirements of the PPACA are amended by any federal law.

- **Organ, eye, or tissue transplantation; discrimination prohibited.** HB 1273/SB 846 amends and reenacts things like § 38.2-4319 of the Code and by adding a section numbered 38.2-3418.18. These amendments provide that an individual who is a candidate to receive an anatomical gift for organ, eye, or tissue transplantation and who is otherwise eligible to receive such gift shall not be deemed ineligible to receive an anatomical gift or denied services related to organ, eye, or tissue transplantation solely because of his physical, intellectual, developmental, or other disability. The bill also prohibits each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services, whose policy, contract, or plan, including any certificate or evidence of coverage issued in connection with such policy, contract, or plan, includes coverage for services related to organ, eye, or tissue transplantation, including referral to a transplant center or specialist, inclusion on an organ, eye, or tissue transplantation waiting list, evaluation, surgery and related health care services, counseling, and post-transplantation treatment and services, from (i) denying coverage to a covered person solely on the basis of the person's disability; (ii) denying a person eligibility or continued eligibility to enroll or to renew coverage under the policy, contract, or plan for the purpose of avoiding the requirements of the bill; (iii) penalizing a health care provider, reducing or limiting the reimbursement of a health care provider, or providing monetary or nonmonetary incentives to a health care provider to induce such health care provider to act in a manner inconsistent with the requirements of the bill; or (iv) reducing or limiting coverage for services related to organ, eye, or tissue transplantation, including referral to a transplant center or specialist,

inclusion on an organ, eye, or tissue transplantation waiting list, evaluation, surgery and related health care services, counseling, and post-transplantation treatment and services. The bill applies to any such policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2021.

- **Pharmacy benefits managers; licensure and regulation.** HB 1290/SB 251 amends and reenacts §§ 38.2-4214 and 38.2-4319 of the Code and amends the Code by adding in Chapter 34 of Title 38.2 an article numbered 9, consisting of sections numbered 38.2-3465 through 38.2-3470. These amendments Provides that no person is authorized to provide pharmacy benefits management services or otherwise act as a pharmacy benefits manager without first obtaining a license from the State Corporation Commission. The measure prohibits a carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager from (i) causing or knowingly permitting the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue; (ii) charging a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for an initial claim submission; (iii) reimbursing a pharmacy or pharmacist an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services, calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting all drug manufacturer's rebates, direct and indirect administrative fees, and costs and any remuneration; or (iv) penalizing or retaliating against a pharmacist or pharmacy for exercising rights provided by this measure. The measure also prohibits a carrier from (a) imposing provider accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the Virginia Board of Pharmacy or other state or federal entity; (b) including any mail order pharmacy or pharmacy benefits manager affiliate in calculating or determining network adequacy; or (c) conducting spread pricing in the Commonwealth. The measure also imposes recordkeeping and reporting requirements. This bill incorporates HB 1292, HB 1459, HB 1479, and HB 1659. **The bill has a delayed effective date of October 1, 2020.**

- **Health insurance; in-network guarantees.** HB 1331 amends the Code by adding a section numbered 38.2-3445.2. This amendment prohibits a health carrier that offers a managed care plan from entering into, extending, or renewing a provider contract with a facility unless such provider contract contains provisions requiring that each health care provider (i) that provides emergency or ancillary services at the facility is an in-network provider or has agreed to have his reimbursement from the health carrier included as part of the health carrier's payment to the facility and to not separately bill the health carrier or the covered person for emergency or ancillary services provided at such facility and (ii) that any laboratory or diagnostic services provided at the facility are in-network or, if such services are referred by a provider at the facility, the referral is to an in-network provider.

- **Health insurance; provider contracts; business practices; penalties.** HB 1384 amends and reenacts § 38.2-3407.15 of the Code. This amendment provides that amendments to a provider contract or any material provision, addenda, schedule, exhibit, or policy thereto, as it relates to any material provision that was agreed to or accepted by the provider in the previous 12-month period, or that occurred during the current term of the provider contract and resulted in an adverse change, are not effective unless agreed to by the provider in writing. The measure requires such an amendment to be agreed to by the provider in a signed written amendment to the provider contract. The measure defines a material provision of a provider contract as any policy manual, coverage guideline, edit, multiple procedure logic, or audit procedure that (i) decreases the provider's payment or compensation, (ii) limits an enrollee's access to covered services under his health plan, or (iii) changes the administrative procedures applicable to a provider contract in a way that may reasonably be expected to significantly increase the provider's administrative expense. The measure requires carriers to permit a provider to determine the carrier's policies regarding the use of edits or multiple procedure logic. The measure requires carriers to provide, for each health plan in which the provider participates or is proposed to participate, a complete fee schedule for all health care services included under the provider contract with the provider in writing and to make such fee schedules available in machine-readable electronic format. The measure requires a provider contract to permit a provider a minimum of one year from the date a health care service is rendered to submit a claim for payment, unless otherwise agreed upon. The measure also (a) requires the State Corporation Commission to assist providers and to examine and investigate provider complaints and inquiries relating to an alleged or suspected failure by a carrier to comply with required minimum fair business standards, (b) requires the Commission to provide a determination of whether a carrier has failed to comply with these standards within 60 days of receipt of a provider's complaint or inquiry, (c) authorizes the Commission to determine whether a carrier's practices comply with these standards, (d) subjects a person that refuses or fails to provide information in a timely manner to the Commission to enforcement and penalty provisions, and (e) authorizes the Commission to impose penalties or issue a cease and desist order to a carrier that fails to comply with these standards.

- **Price transparency for prescription drugs for the treatment of diabetes; civil penalty.** HB 1405 adds sections in Chapter 34 of Title 38.2, like an article numbered 9, consisting of sections numbered 38.2-3465, 38.2-3466, and 38.2-3467.

- **Reproductive health services.** HB 1445 amends and reenacts sections like §§ 38.2-3407.5:1, 38.2-3451, and 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18. These amendments require health benefit plans to cover the costs of specified health care services, drugs, devices, products, and procedures related to reproductive health. The health benefit plan requirements become effective when a plan is delivered, issued for delivery, reissued, or extended in the Commonwealth on and after

January 1, 2021, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made. The measure also requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of the costs of a reproductive health care program providing reimbursement for medically necessary reproductive health care services, drugs, devices, products, and procedures for eligible individuals.

- **Physicians; medical specialty board certification options.** HB 1449 amends and reenacts sections like §§ 38.2-2806, 38.2-4214, and 38.2-4319 of the Code and amends the Code by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.21 and by adding a section numbered 54.1-2912.1:1. These amendments prohibit requiring maintenance of certification from physicians licensed to practice medicine in the Commonwealth, as a prerequisite to hospital medical staff membership, employment, malpractice liability insurance coverage, network status, or reimbursement for services provided to a person covered by a health insurance policy.

- **Health insurance; coverage for autism spectrum disorder.** HB 1503/SB 1031 amends and reenacts § 38.2-3418.17 of the Code. This amendment requires health insurers, corporations providing health care subscription plans, and health maintenance organizations to provide coverage for the diagnosis and treatment of autism spectrum disorder under insurance policies, subscription contracts, or health care plans issued in the individual market or small group markets. The existing requirement that such coverage be provided for policies, contracts, or plans issued in the large group market is not affected. 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, 2021. This bill incorporates HB 1043.

- **Pharmacists; prescribing, dispensing, and administration of controlled substances.** HB 1506 amends and reenacts sections like § 38.2-3408 of the Code. These amendments allow a pharmacist to initiate treatment with and dispense and administer certain drugs and devices to persons 18 years of age or older in accordance with a statewide protocol developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health. The bill directs the Board of Pharmacy to establish such protocols by November 1, 2020, to promulgate emergency regulations to implement the provisions of the bill, and to convene a work group to provide recommendations regarding the development of protocols for the initiating of treatment with and dispensing and administering of additional drugs and devices for persons 18 years of age and older. The bill also clarifies that an accident and sickness insurance policy that provides reimbursement for a service that may be legally performed by a licensed pharmacist shall provide reimbursement for the initiating of treatment with and dispensing and administration of controlled substances by a pharmacist when such initiating of treatment

with or dispensing or administration is in accordance with regulations of the Board of Pharmacy.

- **Prescription drug price transparency; penalties.** HB 1559 amends the Code by adding in Title 38.2 a chapter numbered 65, consisting of sections numbered 38.2-6500 through 38.2-6506. This amendment requires pharmaceutical drug manufacturers, pharmacy benefits managers, and health carriers to submit reports containing certain information concerning prescription drug costs to the Commissioner of the Bureau of Insurance (the Commissioner). The measure requires pharmaceutical drug manufacturers' reports to include information on the current wholesale acquisition cost information for FDA-approved drugs sold in or into the Commonwealth by the pharmaceutical drug manufacturer. The bill also requires such manufacturers to submit a report for drugs with a wholesale acquisition cost of at least $50 for a 30-day supply when their wholesale acquisition cost increases by 25 percent or more over the preceding three calendar years or 10 percent or more over the preceding calendar year. The measure requires pharmacy benefits managers to report data on the aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers and the aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were health benefit plan issuers or enrollees at the point of sale of a prescription drug. The measure requires health carriers to report the names of the 25 most frequently prescribed drugs across all plans, percent increase in annual net spending for drugs across all plans, percent increase in premiums attributable to drugs across all plans, percentage of specialty drugs with utilization management requirements across all plans, and premium reductions that were attributable to specialty drug utilization management. The measure requires the Commissioner to publish the aggregated data from these reports on a website. The measure authorizes the State Corporation Commission (the Commission) to (i) call public hearings and to subpoena prescription drug manufacturers, pharmacy benefits managers, and health carriers to explain their reports; (ii) conduct audits of data submitted to it; (iii) require these entities to submit a corrective action plan to correct deficiencies in reporting; and (iv) impose penalties of $30,000 per day on any prescription drug manufacturer, pharmacy benefits manager, or health carrier that fails to make a good faith effort to submit a required report within two weeks after receiving written notice from the Commission.

- **Health insurance; coverage for infertility treatments.** HB 1567 amends and reenacts § 38.2-4319 of the Code and to amends the Code by adding a section numbered 38.2-3418.18. The amendments require health insurance policies, subscription contracts, and health care plans to provide coverage for embryo transfer, in vitro fertilization, artificial insemination, gamete intrafallopian tube transfer, intracytoplasmic sperm injection, zygote intrafallopian transfer, and low tubal ovum transfer when performed on a covered individual who is less than 50 years old and infertile.

- **Health benefit plans; coding for adverse childhood experiences.** HB 1682 amends the Code by adding a section numbered 38.2-3407.10:3. This amendment requires any carrier that offers a health benefit plan that provides coverage for screening of covered persons for adverse childhood experiences that may impact a patient's physical or mental health or the provision of health care services to such patient to utilize a coding system that enrolls a code for such screening services.

- **Health insurance; coverage for case management services and peer support services.** HB 1704 amends and reenacts § 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18. These amendments require health insurance policies, subscription contracts, and health care plans to provide coverage for (i) case management services that are prescribed by a licensed physician for a covered individual who has a primary diagnosis of a substance abuse disorder and (ii) peer support services for any covered person who has a primary diagnosis of a mental health disorder other than substance abuse disorder.

- **Essential health benefits; abortion coverage.** HB 1713 amends and reenacts § 38.2-3451 of the Code. This amendment removes the prohibition on the provision of coverage for abortions in any qualified health insurance plan that is sold or offered for sale through a health benefits exchange established or operating in Virginia.

- **Health care provider panels; vertically integrated carriers; providers.** HB 1731 amends and reenacts §§ 38.2-3407.10 and 38.2-4319 of the Code. These amendments require any vertically integrated carrier to offer participation in each provider panel or network established for each of the vertically integrated carrier's policies, products, and plans, including all policies, products, and plans offered to individuals, employers, and enrollees in state and federal government benefit programs, to every provider in the Commonwealth under the same terms and conditions that apply to providers under common control with the vertically integrated carrier.

- **Health insurance; physical therapist office visit; cost-sharing requirements.** SB 192 amends the Code by adding a section numbered 38.2-3407.9:06. This amendment prohibits health insurers, corporations providing health care coverage subscription contracts, and health maintenance organizations whose policies, contracts, or plans include coverage for physical therapy from imposing any cost-sharing requirements such as a copayment, coinsurance, or deductible for a physical therapist office visit that exceeds the cost-sharing requirements for a physician or osteopath office visit.

- **Virginia Health Benefit Exchange.** SB 226 amends and reenacts §§ 38.2-4214, 38.2-4319, and 38.2-4509 of the Code; amends the Code by adding in Title 38.2 a chapter numbered 65, consisting of sections numbered 38.2-6500 through 38.2-6515; and repeals the second enactments of Chapters 670 and 679 of the Acts of Assembly of 2013. These

amendments create the Virginia Health Benefit Exchange, which will be established and operated by a new division within the State Corporation Commission (SCC). The Exchange shall facilitate the purchase and sale of qualified health plans and qualified dental plans to qualified individuals and qualified employers.

- **Health insurance; association health plans.** SB 235 amends and reenacts §§ 38.2-3431, 38.2-3437, and 38.2-3521.1 of the Code. These amendments provide that for policies of group accident and sickness insurance issued to an association, members of such an association may include (i) a self-employed individual and (ii) an employer member with at least one employee that is domiciled in the Commonwealth.

- **Balance billing; emergency services.** SB 243 amends and reenacts §§ 38.2-3438 and 38.2-3445 of the Code. These amendments provide that when a covered person receives covered emergency services from an out-of-network health care provider, the covered person is not required to pay the out-of-network provider any amount other than the applicable cost-sharing requirement. The measure deletes a provision that allows an out-of-network provider to charge an individual for the balance of the provider's billed amount after applying the amount the health carrier is required to pay for such services. The measure also establishes a fourth standard for calculating the health carrier's required payment to the out-of-network provider of the emergency services, which standard is (i) the regional average for commercial payments for such service if the provider is a health care professional or (ii) the fair market value for such services if the provider is a facility.

- **Medicare supplement policies for certain individuals under age 65.** SB 250 amends and reenacts §§ 38.2-4214 and 38.2-4319 of the Code and amends the Code by adding in Chapter 36 of Title 38.2 a section numbered 38.2-3610. These amendments require each insurer issuing Medicare supplement policies or certificates in the Commonwealth to offer the opportunity of enrolling in at least one of its issued Medicare supplement policies or certificates to any individual under age 65 who resides in the Commonwealth, is enrolled in Medicare Part A and B, and is eligible for Medicare by reason of disability. The provisions of the measure are applicable to health plans and health maintenance organizations.

- **Health insurance; mental health parity; required report.** SB 280 amends and reenacts § 38.2-3412.1 of the Code and repeals the third enactment of Chapter 649 of the Acts of Assembly of 2015. This amendment codifies an existing requirement that the State Corporation Commission's Bureau of Insurance make an annual report regarding claims information for mental health and substance use disorder benefits.

- **Health insurance; mandated coverage for hearing aids for minors.** SB 423 amends and reenacts § 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18. Requires health insurers, health maintenance organizations, and corporations

providing health care coverage subscription contracts to provide coverage for hearing aids and related services for children 18 years of age or younger when an otolaryngologist recommends such hearing aids and related services.

- **Health plans; calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement; rebates.** SB 424 amends and reenacts § 38.2-3407.20 of the Code. This amendment requires any carrier issuing a health plan in the Commonwealth to count the amount of any rebates received or to be received by the carrier or its pharmacy benefits manager in connection with the dispensing or administration of a prescription drug when calculating the enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under the carrier's health plan.

- **Balance billing; emergency and elective services.** SB 522 amends and reenacts §§ 38.2-3438 and 38.2-3445 of the Code and amends the Code by adding a section numbered 38.2-3445.2. These amendments require health care facilities and health care providers to determine if providers scheduled to deliver elective services to a covered person are in the network of the covered person's managed care plan.

- **Disability insurance; childbirth.** SB 567 amends the Code by adding a section numbered 38.2-3407.11:4. This amendment requires each insurer proposing to issue individual or group accident and sickness insurance policies providing short-term disability income protection coverage whose policies provide coverage for short-term disability arising out of childbirth to provide coverage for a payable benefit of at least 12 weeks following childbirth for such a disability.

- **Health insurance; interhospital transfer for newborn or mother.** SB 718 amends the Code by adding a section numbered 38.2-3407.11:4. This amendment prohibits health insurers from requiring prior authorization for the interhospital transfer of (i) a newborn infant experiencing a life-threatening emergency condition or (ii) the hospitalized mother of such newborn infant to accompany the infant.

- **Health insurance; provider contracts; business practices; penalties.** SB 765 amends and reenacts § 38.2-3407.15 of the Code. This amendment prohibits a carrier from unilaterally amending a provider contract or any material provision, addenda, schedule, exhibit, or policy thereto, as it relates to any material provision that was agreed to or accepted by the provider in the previous 12-month period.

- **Group health benefit plans; bona fide associations; benefits consortium.** SB 861 amends and reenacts sections like §§ 38.2-508.5, 38.2-3420, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, and 38.2-3521.1 of the Code. These amendments provide that certain trusts constitute a benefits consortium and are authorized to sell health benefits plans to members of a sponsoring association that (i) has been formed and maintained in good faith for purposes other than obtaining or providing health benefits; (ii) does not condition

membership in the sponsoring association on any factor relating to the health status of an individual, including an employee of a member of the sponsoring association or a dependent of such an employee; (iii) makes any health benefit plan available to all members regardless of any factor relating to the health status of such members or individuals eligible for coverage through a member; (iv) does not make any health benefit plan available to any person who is not a member of the association; (v) makes available health plans or health benefit plans that meet requirements provided for in the bill; (vi) operates as a nonprofit entity under § 501(c)(5) or 501(c)(6) of the Internal Revenue Code; and (vii) has been in active existence for at least five years.

- **Health care provider panels; vertically integrated carriers; providers.** SB 867 amends and reenacts §§ 38.2-3407.10 and 38.2-4319 of the Code. These amendments require any vertically integrated carrier to offer participation in each provider panel or network established for each of the vertically integrated carrier's policies, products, and plans, including all policies, products, and plans offered to individuals, employers, and enrollees in state and federal government benefit programs, to every provider in the Commonwealth under the same terms and conditions that apply to providers under common control with the vertically integrated carrier.

- **Reproductive health services.** SB 917 amends and reenacts sections like §§ 38.2-3407.5:1, 38.2-3451, and 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18. These amendments require health benefit plans to cover the costs of specified health care services, drugs, devices, products, and procedures related to reproductive health.

- **Pharmacists; initiating treatment, dispensing, and administering of controlled substances.** SB 1026 amends and reenacts sections like §§ 38.2-3408 of the Code. These amendments include in the practice of pharmacy initiating treatment, dispensing, and administering of certain drugs and devices by a pharmacist, provided that such pharmacist initiates treatment with, dispenses, or administers such drugs and devices in accordance with a statewide protocol developed by the Board of Pharmacy in collaboration with the Board of Medicine and Department of Health and set forth in regulations of the Board of Pharmacy.

- **Health insurance; narrow network plans.** SB 1047. Prohibits a health carrier from offering more than one narrow network plan, as defined in the bill, in a geographic region if any two narrow network plans offered by the health carrier would have the two lowest monthly premiums of any silver-level plans offered by the health carrier in the geographic region.

- **Health insurance; coverage for infertility treatment.** SB 1086 amends and reenacts § 38.2-4319 of the Code and amends the Code by adding a section numbered 38.2-3418.18.

These amendments require health insurance policies, subscription contracts, and health care plans, including plans administered by the Department of Medical Assistance Services, to provide coverage for infertility treatment.

- **Life insurance; notarized signature.** HB 487 amends the Code by adding a section numbered § 38.2-3301.2. The amendment requires that any individual life insurance policy delivered or issued for delivery on or after January 1, 2021, contain the notarized signature of the individual on whose life the policy is issued.

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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 2020. If you have any questions or would like additional information, please contact Scott Sorkin at ssorkin@blandsorkin.com.