# Summary of Certain 2021 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, 2021 (except as otherwise indicated). The following is a brief summary of some of the amendments that may be of interest.

## General Changes:

- **Public adjusters; continuing education requirements.** HB 1942 amends and reenacts §§ 38.2-1866, 38.2-1867, 38.2-1868.1, 38.2-1869, 38.2-1871, and 38.2-1873 of the Code and repeals § 38.2-1845.9 of the Code, relating to public adjusters; continuing education. These changes provide for continuing education requirements for public adjusters and that the insurance continuing education board (the Board), appointed by the State Corporation Commission, is responsible for establishing and monitoring standards for such requirements. Currently, the Commission is given such responsibility and the Board is responsible for the continuing education requirements for other insurance agents and agencies. The bill maintains the current requirement that a public adjuster complete a minimum of 24 hours of approved credits, including three hours of ethics, on a biennial basis.

- **Issuance or renewal of insurance licenses or registrations during an emergency.** SB 1255 amends and reenacts § 38.2-200 of the Code, relating to State Corporation Commission; issuance or renewal of insurance licenses or registrations during an emergency. This Bill authorizes the State Corporation Commission to temporarily suspend, authorize extensions of time, or waive requirements for the issuance or renewal of licenses or registrations related to insurance in the event of an emergency.

- **Income tax, state; voluntary inclusion of personal & contact information on appropriate forms.** HB 1884 amends and reenacts sections like § 38.2-6505 of the Code. These amendments direct the Department of Taxation to include space on the appropriate individual income tax forms for voluntary inclusion of personal and contact information. Such information may be shared with the Department of Medical Assistance Services, the Department of Social Services, or the Virginia Health Benefit Exchange, as applicable, for use in determining eligibility for certain programs. Beginning with tax year 2022, the

Department of Taxation shall also include a checkoff box for taxpayers to indicate their consent to the sharing of tax information with the Department of Medical Assistance Services and the Department of Social Services. Beginning with tax year 2023, there shall also be included a checkoff box for taxpayers to indicate their consent to the sharing of tax information with the Virginia Health Benefit Exchange. The bill contains provisions allowing disclosure of such information in accordance with the act. The bill also directs the Virginia Health Benefit Exchange to, in consultation with other government agencies and stakeholders, identify systems, policies, and practices to facilitate eligibility determinations and enrollment.

- **Paid family leave; SCC's Bureau of Insurance to review and make recommendations, report.** SB 1219 directs the State Corporation Commission's Bureau of Insurance (the Bureau) to review and make recommendations, including any necessary statutory and regulatory changes, to authorize the State Corporation Commission to approve the sale of individual and group paid family leave plans in Virginia. The bill requires the Bureau to also identify options and make recommendations for encouraging or incentivizing employers to voluntarily offer up to 12 weeks of paid family leave. The bill requires the Bureau to convene a stakeholder group to participate in the process, which is required to include representatives from the insurance industry and the business community, advocates for paid family leave, and other interested parties. The bill requires the Bureau to report its findings and recommendations to the Senate Committees on Commerce and Labor and Finance and Appropriations and the House Committees on Labor and Commerce and Appropriations by November 30, 2021.

## Property & Casualty:

- **Property and casualty insurance form; approval of form by State Corporation Commission.** HB 1892 amends and reenacts § 38.2-317 of the Code, relating to approval of property and casualty insurance policy forms and endorsements. This amendment permits an insurer that receives approval of an insurance policy form or endorsement from the State Corporation Commission to use the form as soon as it is approved rather than waiting 30 days after the filing date to use it as is current law.

- **Motor vehicle insurance; underinsured motor vehicle, uninsured motorist coverage.** SB 1195 amends and reenacts § 38.2-2206 of the Code, relating to motor vehicle insurance; underinsured motor vehicle. This amendment provides that a policy or contract of bodily injury and property damage liability insurance for the use of a motor vehicle shall contain an endorsement or provisions obligating the insurer to make payment for injury or damage caused by an underinsured vehicle without any credit, set-off, or reduction for the available bodily injury and property damage coverage. The bill provides that a motor vehicle is underinsured when the total amount of bodily injury and property damage coverage

applicable to the operation or use of the motor vehicle and available for payment for such bodily injury or property damage, is less than the total amount of damages sustained up to the total amount of uninsured motorist coverage afforded any person injured.

- **Uninsured and underinsured motorist insurance policies; bad faith.** SB 1202 amends and reenacts sections like § 38.2-2206 of the Code, relating to uninsured and underinsured motorist insurance policies; bad faith. These changes provides 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 is liable to the insured for the full amount of the judgment and reasonable attorney fees, expenses, and interest.

## Life & Health:

- **Health maintenance organizations; insolvency.** HB 1807 amends and reenacts § 38.2-4310 of the Code. This change updates provisions of the Code related to insolvency procedures for health maintenance organizations (HMOs) that were inconsistent with the method to address insolvencies provided for members of the Virginia Life, Accident and Sickness Insurance Guaranty Association. HMOs became members of the Association following legislation passed during the 2018 Session.

- **Health insurance; cost-sharing payments for prescription asthma inhalers.** HB 1822 amended the Code by adding § 38.2-3407.15:6, relating to health insurance; cost-sharing payments for prescription asthma inhalers. This addition prohibits health insurance companies and other carriers from setting an amount exceeding $50 per 30-day supply of a tier one or tier two prescription asthma inhaler that a covered person is required to pay at the point of sale in order to receive a covered prescription asthma inhaler unless the carrier is prohibited from providing the additional benefits under state or federal law. 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 asthma inhaler in an amount that exceeds such limitation. The provisions apply with respect to health plans and provider contracts entered into, amended, extended, or renewed on or after January 1, 2022.

- **Health insurance; credentialing; health care providers.** HB 1829 amends and reenacts §§ 38.2-4319 and 38.2-4509 of the Code. These amendments provide that provisions requiring health insurers and other carriers to establish reasonable protocols and procedures for reimbursing a health professional for services provided while such professional's

credentialing application is pending also apply to certain health maintenance organizations and to corporations operating dental or optometric plans.

- **Essential health benefits; abortion coverage.** HB 1896/SB 1276 amends and reenacts § 38.2-3451 of the Code, relating to health insurance; essential health benefits; abortion coverage. 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.

- **Medical assistance; coverage for reproductive health services.** HB 1922 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 § 38.2-3418.21, relating to coverage for reproductive health care services. These changes direct 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 reproductive health care services for eligible individuals and provides that medical benefits required to be provided to individuals eligible for medical assistance under the Family Access to Medical Insurance Security (FAMIS) Plan shall include reproductive health care services for which the payment of medical assistance is required under the state plan for medical assistance. The bill directs the Board of Medical Assistance Services to adopt emergency regulations to implement the provisions of the bill. The bill also requires 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, 2022, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made.

- **Telemedicine; coverage of telehealth services by an insurer, etc.** HB 1987 amends and reenacts sections like § 38.2-3418.16 of the Code, relating to telemedicine. These amendments require the Board of Medical Assistance Services to amend the state plan for medical assistance to provide for payment of medical assistance for remote patient monitoring services provided via telemedicine for certain high-risk patients, makes clear that nothing shall preclude health insurance carriers from providing coverage for services delivered through real-time audio-only telephone that are not telemedicine, and clarifies rules around prescribing of Schedule II through VI drugs via telemedicine, including establishing a practitioner-patient relationship via telemedicine.

- **Prescription drugs; price transparency, definitions.** HB 2007 amends and reenacts the Code by adding in sections like Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.22. These changes direct the Department of Health to enter into a contract or an agreement with a nonprofit data services organization to collect, compile, and make available on its website information about prescription drug pricing and requires every

health carrier, pharmacy benefits manager, and drug manufacturer to report information about prescription drug prices to the nonprofit data services organization with which the Department of Health has entered into a contract for such purpose. The bill provides that in any case in which the Department determines that the data reported by health carriers, pharmacy benefit managers, and drug manufacturers is insufficient, the Department may require wholesale distributors to report certain data about prescription drug costs. **The bill has a delayed effective date of January 1, 2022**.

- **Health insurance; authorization of drug prescribed for the treatment of a mental disorder, etc.** HB 2008 amends and reenacts § 38.2-3407.15:2 of the Code, relating to health insurance; authorization of drug prescribed for the treatment of a mental disorder. This amendment requires that any provider contract between a carrier and a participating health care provider with prescriptive authority, or its contracting agent, contain provisions that require, when a carrier has previously approved prior authorization for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, no additional prior authorization can be required if (i) the drug is a covered benefit, (ii) the prescription does not exceed the U.S. Food and Drug Administration-labeled dosages, (iii) the prescription has been continuously issued for no fewer than three months, and (iv) the prescriber performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications. The bill provides that this requirement does not prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug formulary at the time the initial prescription is issued. The bill also provides that such provider contracts contain provisions requiring a carrier to honor a prior authorization issued by the carrier for a drug regardless if the drug is removed from the carrier's prescription drug formulary after the initial prescription is issued.

- **Health insurance; provider contracts, report.** HB 2021 amends and reenacts § 38.2-3407.15 of the Code, relating to health insurance; provider contracts; report. This amendment prohibits a carrier from unilaterally amending any material provision of a provider contract or adding any new material provision to any provider contract within 12 months of execution of the provider contract or the date of last amendment to the provider contract. The measure requires such an amendment to be agreed to by the provider in a written amendment to the provider contract. The measure requires that carriers supply fee schedules in writing, make fee schedules available in machine-readable electronic format, and provide the complete fee schedule applicable to the provider for each health plan in which the provider participates or is proposed to participate. The measure requires that amendments be presented in a manner so as to allow the provider to easily identify the specific terms being proposed for amendment and that proposed amendments be formatted to clearly identify the changes to the language of the agreement. The measure requires

provider contracts to permit a provider a minimum of 180 days from the date a health care service is rendered to submit a claim for payment. The measure also (i) requires the State Corporation Commission to promulgate regulations to establish a procedure for accepting and resolving complaints relating to an alleged or suspected failure to comply with the minimum fair business standards as it relates to any provider or carrier, (ii) authorizes the Commission to investigate complaints, (iii) subjects a person that refuses or fails to provide information in a timely manner to the Commission to enforcement and penalty provisions, and (iv) requires the Commission to report annually on the complaints received and the results of any investigation made to the House Committees on Labor and Commerce and Health, Welfare and Institutions and the Senate Committees on Commerce and Labor and Education and Health and to the Joint Commission on Health Care.

- **Health insurance; association health plan for real estate salespersons.** HB 2033/SB 1341 amends and reenacts § 38.2-3521.1 of the Code, relating to health insurance; association health plan for real estate salespersons. This amendment provides that a licensed insurer may issue a policy of group accident and sickness insurance to an association of real estate salespersons (association), and that such association health plan is not considered to be insurance and is not subject to the existing requirements for insurance if certain requirements are met. The bill requires that (i) all members of the association be eligible for coverage and membership, including employer members with at least one employee that is domiciled in the Commonwealth or self-employed individuals; (ii) membership in the association not be conditioned on any health status-related factor; (iii) the coverage offered through the association be available to all members regardless of any health status-related factor; (iv) the association not make health insurance coverage offered through the association available other than in connection with a member of the association; and (v) premiums for the policy be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members. The bill also requires that the association (a) has at the outset a minimum of 100 members; (b) has been organized and maintained in good faith for purposes other than that of obtaining insurance; (c) has been in active existence for at least five years; and (d) has a constitution and bylaws that provide that the association hold regular meetings. The bill provides that any such policy shall (1) be considered a large group market plan subject to all coverage mandates applicable to a large group market plan, (2) be subject to the group health plan coverage requirements under the federal Patient Protection and Affordable Care Act, (3) be prohibited from denying coverage under the policy on the basis of a pre-existing condition, (4) be guaranteed issue and guaranteed renewable, (5) provide essential health benefits and cost-sharing requirements, and (6) offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan. The bill requires an insurer issuing such policy to an association to (A) treat all of the

members and employees of employer members who are enrolled in coverage under the policy as a single risk pool; (B) set premiums on the basis of the collective group experience of the members and employees of employer members who are enrolled in coverage under the policy; (C) not vary premiums by age, except that the rate shall not vary by more than four to one for adults; (D) not vary premiums on the basis of gender; (E) not vary premiums on the basis of the health status of an individual employee of an employer member or a self-employed individual member; and (F) not establish discriminatory rules based on the health status of an employer member, an individual employee of an employer member, or a self-employed individual for eligibility or contribution.

- **Pharmacies; freedom of choice by covered individual.** HB 2219 amends and reenacts §§ 38.2-3407.7, 38.2-4209.1, and 38.2-4312.1 of the Code, relating to pharmacies; freedom of choice. These changes provide that no insurance carrier, corporation providing preferred provider subscription contracts, or health maintenance organization providing health care plans or its pharmacy benefits manager shall prohibit a covered individual from selecting the pharmacy of his choice to furnish specialty pharmaceutical benefits under the covered individual's policy. The bill provides that no pharmacy that meets the terms and conditions of participation shall be precluded from obtaining a direct service agreement or participating provider agreement and that any request for such agreement by a pharmacy shall be acted upon by a carrier, corporation, or organization or its pharmacy benefits manager within 60 days of receiving the request.

- **Health insurance; carrier business practices, provider contracts.** HB 2274 amends and reenacts § 38.2-3407.15 of the Code, relating to health insurance; carrier business practices; provider contracts. This amendment requires that each provider contract include provisions (i) requiring providers to provide health care services to enrollees in a manner similar to any other individual and (ii) prohibiting a provider from discriminating against any enrollee as a result of the enrollee's enrollment in a health plan or on the basis of the enrollee's race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health care services, status as a litigant except in cases where the enrollee claims medical malpractice by the provider, status as a Medicare enrollee, status as a medical assistance recipient, sexual orientation or gender identity, or on any other basis prohibited by law. The bill prohibits a provider contract from requiring a provider to provide any health care service to enrollees that it does not customarily provide to others. The bill provides that a provider that violates the anti-discrimination provisions may be subject to fines and other discipline. The bill also prohibits a provider contract from (a) directly or indirectly restricting the carrier from directing or steering enrollees to other health care providers or offering incentives to encourage enrollees to utilize specific providers; (b) requiring the carrier to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider or to agree to payment rates or other terms for any affiliate not party to the contract of the

provider involved; or (c) restricting other carriers not party to the contract from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services. The bill prohibits a provider from terminating or failing to renew the contractual relationship with a carrier, or provider, for invoking any of the carrier's rights. The bill states that a provider or carrier injured as a result of a violation or threatened violation of any provision governing carrier business practices is entitled to injunctive relief. The bill requires a provider contract to permit a provider a maximum of 90 days from the date a health care service is rendered to submit a claim for payment. The bill requires carriers to supply fee schedules in writing and in machine-readable electronic format and to provide the complete fee schedule applicable to the provider for each health plan in which the provider participates or is proposed to participate. The bill requires that amendments to a provider contract be presented in a manner to allow the provider to easily identify the specific terms being proposed for amendment and that proposed amendments be formatted to clearly identify the changes to the language of the agreement.

- **Commonwealth Health Reinsurance Program; established, report.** HB 2332 amends and reenacts §§ 38.2-4214 and 38.2-4319 of the Code and to amend the Code by adding in Title 38.2 a chapter numbered 66, consisting of sections numbered 38.2-6600 through 38.2-6607, relating to the Commonwealth Health Reinsurance Program; established; special fund established; assessment; federal waiver application. These changes require the State Corporation Commission (Commission) to establish, upon approval of a state innovation waiver request pursuant to § 1332 of the Affordable Care Act, a reinsurance program, known as the Commonwealth Health Reinsurance Program (the Program). The bill provides that the Program is funded through federal funding provided under the state innovation waiver, an assessment on carriers, and state appropriations. The bill requires that the Commission impose an annual assessment of one percent of a carrier's net written premiums on entities authorized to issue individual and group health insurance overage including grandfathered plans but excluding plans offered in the small group market. The bill provides requirements for payment parameters, data submissions, recordkeeping, reporting, and audits of health carriers. The bill requires the Secretary of Health and Human Resources to convene a work group to develop recommendations for developing a state-based subsidy program to increase affordability of health plans to individuals and to increase enrollment in the Virginia Health Benefit Exchange. The bill requires the Commission to evaluate the program following its second year of operation. The provisions of the bill, other than the requirements that the Commission apply for the state innovation waiver, will become effective 30 days after notice of approval of the waiver request.

- **Health insurance; authorization of drug prescribed for the treatment of a mental disorder.** SB 1269 amends and reenacts § 38.2-3407.15:2 of the Code, relating to health insurance; authorization of drug prescribed for the treatment of a mental disorder. The amendment requires that any provider contract between a carrier and a participating health

care provider with prescriptive authority, or its contracting agent, contain provisions that require, when a carrier has previously approved prior authorization for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, no additional prior authorization can be required if (i) the drug is a covered benefit, (ii) the prescription does not exceed the U.S. Food and Drug Administration-labeled dosages, (iii) the prescription has been continuously issued for no fewer than three months, and (iv) the prescriber performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications. The bill provides that this requirement does not prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug formulary at the time the initial prescription is issued. The bill also provides that such provider contracts contain provisions requiring a carrier to honor a prior authorization issued by the carrier for a drug regardless if the drug is removed from the carrier's prescription drug formulary after the initial prescription for that drug is issued. Under the bill, provisions related to provider contracts and prior authorization will apply to the state insurance health plan.

- **Health insurance; carrier business practices, etc.** SB 1289 amends and reenacts § 38.2-3407.15 of the Code, relating to health insurance; carrier business practices; provider contracts. This amendment requires that each provider contract include a provision prohibiting a provider from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. The bill provides that the State Corporation Commission, if it has cause to believe that a provider has engaged in a pattern of such discrimination, may submit information to the Board of Medicine or the Commissioner of Health for action.

- **Telemedicine services; remote patient monitoring services.** SB 1338 amends and reenacts sections like § 38.2-3418.16 of the Code, relating to telemedicine services; remote patient monitoring services. These amendments require 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 remote patient monitoring services provided via telemedicine for (i) high-risk pregnant persons; (ii) medically complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three months following the date of such surgery; and (v) patients with a chronic health condition who have had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months. The services include monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data; treatment adherence monitoring; and interactive video conferencing with or without digital image upload. The bill also clarifies the definition of "telemedicine services" to provide that nothing in the bill precludes coverage for a service

that is not a telemedicine service, including real-time audio-only telehealth services. The bill directs the Department of Medical Assistance Services to adopt regulations for reimbursement for telemedicine services delivered through audio-only telephone and to promulgate and adopt uniform regulations for remote patient monitoring for all Medicaid managed care organizations to implement and follow. The provisions of the bill are contingent on funding in a general appropriation act. This bill incorporates SB 1416 and is identical to HB 1987.

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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 2021. If you have any questions or would like additional information, please contact Scott Sorkin at ssorkin@blandsorkin.com.