Summary of Certain 2022 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, 2022 (except as otherwise indicated). The following is a brief summary of some of the amendments that may be of interest.

General Changes:

- **Insurance; obsolete provisions and notice.** HB 62 amends and reenacts §§ 38.2-1902, 38.2-2218, and 38.2-2219 of the Code and repeals §38.2-3515 of the Code, relating to insurance; exceptions to the regulation of rates; notice provisions; repeal airtrip accident policy provision. The bill removes an exception to the regulation of insurance rates by the State Corporation Commission relating to certain automobile bodily injury and property damage liability insurance policies. The bill also removes provisions requiring the Commission to mail a copy of certain orders regarding motor vehicle insurance forms to insurers and rate service organizations and instead requires the Commission to provide notice of such orders. Additionally, the bill repeals a provision requiring that coverage of airtrip accident policies extend in certain cases to connecting or returning planes.

- **Insurance holding company systems; group capital calculation and liquidity stress test.** HB 82 amends and reenacts §§ 38.2-1322, 38.2-1329, 38.2-1330, and 38.2-1333 of the Code, relating to insurance holding company systems; group capital calculation and liquidity stress test; hazardous financial conditions. The bill requires that certain insurers that are members of an insurance holding company system file a group capital calculation in accordance with the National Association of Insurance Commissioners (NAIC) Group Capital Calculation Instructions and a liquidity stress test in accordance with the NAIC Liquidity Stress Test Framework. The bill provides exceptions to such reporting requirements and contains various provisions regarding the confidentiality of information contained in such reports. The bill authorizes the State Corporation Commission to require a deposit or bond when an insurer that is a member of an insurance holding company system is in a hazardous financial condition or a condition that would be grounds for the supervision, conservation, or delinquency proceeding.

- **Insurance; examinations; provider complaints.** HB 146 amends the Code by adding § 38.2-237, relating to insurance; provider complaints; notice of premium increase. The bill provides that any person may submit a complaint of noncompliance by an insurer with any insurance law, regulation, or order of the State Corporation Commission on behalf of a health care provider. The bill provides that the Commission shall investigate such complaints and notify the complainants of the outcomes, but that the Commission shall not have jurisdiction to adjudicate individual controversies or matters of contractual dispute.

- **Practice of licensed professional counselors.** HB 242 amends and reenacts §§ 8.01-413, 8.01-581.20, 16.1-340.1, 20-124.6, 32.1-127.1:03, 37.2-809, 38.2-608, 53.1-40.2, and 54.1-2969 of the Code, relating to practice of licensed professional counselors. The bill adds licensed professional counselors to the list of eligible providers who can disclose or recommend the withholding of patient records, face a malpractice review panel, and provide recommendations on involuntary temporary detention orders.

- **Bureau of Insurance; provider contracts continuity of care.** HB 912 directs the Bureau of Insurance to convene a work group to determine options for ensuring continuity of care covered by insurance for a reasonable amount of time under reasonable conditions during the time that providers and insurance carriers are negotiating provider contracts. The work group will provide recommendations to the General Assembly by December 1, 2022.

- **Private family leave insurance.** HB 1156/SB 15 amends and reenacts §§ 38.2-135, 38.2-316, and 38.2-1800 of the Code and amends the Code by adding a section 38.2-107.2, relating to insurance; private family leave insurance. This bill establishes family leave insurance as a class of insurance. "Family leave insurance" is defined as an insurance policy issued to an employer related to a benefit program provided to an employee to pay for the employee's income loss due to the birth of a child or adoption of a child by the employee, placement of a child with the employee for foster care, care of a family member of the employee who has a serious health condition, or circumstances arising out of the fact that the employee's family member who is a service member is on active duty or has been notified of an impending call or order to active duty. Family leave insurance may be written as an amendment or rider to a group disability income policy, included in a group disability income policy, or written as a separate group insurance policy purchased by an employer. The bill prohibits delivery or issue for delivery of a family leave insurance policy unless a copy of the form and the rate manual showing rates, rules, and classification of risks have been filed with the State Corporation Commission. The bill prohibits an individual certificate and enrollment form from being used in connection with a group family leave insurance policy unless the form for the certificate and enrollment form have been filed with the Commission.

- **Insurance; public adjusters; standards of conduct.** SB 194 amends and reenacts § 38.2-1845.12 of the Code, relating to insurance; public adjusters; standards of conduct. This bill

prohibits a public adjuster from engaging in any activity that may reasonably be construed as a conflict of interest, including soliciting or accepting any remuneration of any kind or nature, directly or indirectly, except as set forth in a public adjusting contract with an insured. Additionally, the bill provides that for the purposes of the prohibition on a public adjuster having a financial interest in an insured's claim, "financial interest" includes participation by a public adjuster, directly or indirectly, in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by that public adjuster.

Property & Casualty:

- **Fire insurance; appraisers and umpires; citizenship requirements.** HB 606 amends and reenacts § 38.2-2122 of the Code, relating to fire insurance; appraisers and umpires; citizenship requirements. This bill removes a requirement that appraisers and umpires who make appraisals for loss or damage to property under the provisions of a fire insurance policy are citizens and residents of the Commonwealth.

- **Motor vehicle insurance; underinsured motor vehicle.** SB754 amends and reenacts §§ 38.2-2202, 38.2-2206, and 46.2-2057 of the Code, relating to motor vehicle insurance; uninsured motorist coverage. This bill requires any motor vehicle liability insurance policy issued, delivered, or renewed in the Commonwealth after July 1, 2023, to include a specific statement regarding the insurer requirements to provide underinsured motorist coverage that pays any damages due to an insured in addition to any bodily injury or property damage liability that is applicable to the insured's damages. The bill requires that the endorsement or provisions of a motor vehicle liability policy to provide uninsured motorist insurance coverage also provide underinsured motorist insurance coverage with limits that are equal to the uninsured motorist insurance coverage limits. Under the bill, underinsured motorist coverage shall be paid without any credit for the bodily injury and property damage coverage available for payment, unless any named insured elects to reduce any underinsured motorist coverage payments by notifying the insurer. If an injured person is entitled to underinsured motorist coverage under one or more policies wherein a named insured has elected to reduce the underinsured motorist limits by the available bodily injury liability insurance or property damage liability insurance coverage available for payment, any amount available for payment shall be credited against such policies in payment priority established in current law, and where there is more than one such policy entitled to such credit, the credit shall be apportioned pro-rata pursuant to the policies' respective available underinsured motorist coverages. The bill also provides that taxicab operators may fulfill their insurance filing requirement by showing evidence of a certificate of self-insurance. The bill requires, with regard to the self-insurance protection of a taxicab operator, the amount of bodily injury or property damage liability coverage available for payment from any source to be credited against and reduce the amount of protection otherwise available against an underinsured motorist.

Life & Health:

- **Standard nonforfeiture provisions for life insurance; minimum nonforfeiture amounts; interest rates.** HB 44 amends and reenacts § 38.2-3221 of the Code relating to standard nonforfeiture provisions for life insurance; minimum nonforfeiture amounts; interest rates. The Bill decreases the minimum nonforfeiture amount interest rate from 1% to 0.15%.

- **Health carriers; licensed athletic trainers.** HB 45/SB 525 amends and reenacts §§ 38.2-3408 and 38.2-4221 of the Code, relating to insurance; reimbursement for services provided by a licensed athletic trainer. This bill requires 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 when such services are performed in an office setting.

- **Health insurance; definition of autism spectrum disorder.** HB 225/SB 321 amends and reenacts § 38.2-3418.17 of the Code, relating to health insurance; coverage for autism spectrum disorder; definition. This bill provides that for purposes of required health insurance coverage for the diagnosis and treatment of autism spectrum disorder, "autism spectrum disorder" means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and "medically necessary" means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

- **Health care data report; carriers.** HB 248 requires the Department of Health, through its contract with the nonprofit organization with which it enters agreements for certain data services, to develop and implement a methodology for evaluating the efficiency and productivity of carriers and managed care health insurance plans, relating to health care data report; carriers. All reports collected or produced as a result of the implementation of such methodology will be made available to the public on a website maintained by the nonprofit organization by July 1, 2023.

- **Virginia Health Benefit Exchange; marketing.** HB 312/SB 469 amends and reenacts § 38.2-6505 of the Code, relating to the Virginia Health Benefit Exchange; marketing. This bill requires the Virginia Health Benefit Exchange to prepare an annual marketing plan that

includes consumer outreach, licensed health insurance agents, and navigator programs. As introduced, this bill was a recommendation of the Joint Commission on Health Care.

- **Health insurance; carrier disclosure of certain information.** HB 360/SB 428 amends and reenacts § 38.2-3407.15:2 of the Code and adds § 38.2-3407.15:7, relating to health insurance; carrier disclosure of certain information. The bill requires each health insurance carrier, **beginning July 1, 2025**, to establish and maintain an online process that (i) links directly to e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard; (ii) can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior authorization requests for which no additional information is needed by the carrier to process the prior authorization request, no clinical review is required, and that meet the carrier's criteria for approval; and (iv) otherwise meets the requirements of the relevant Code of Virginia section. The bill prohibits a carrier from (a) imposing a charge or fee on a participating health care provider for accessing the required online process or (b) accessing, absent provider consent, provider data via the online process other than for the enrollee. The bill requires participating health care providers, beginning July 1, 2025, to ensure that any e-prescribing system or electronic health record system owned by or contracted for the provider to maintain an enrollee's health record has the ability to access the electronic prior authorization process established by a carrier and real-time cost information data for a covered prescription drug made available by a carrier. The bill provides that a provider may request a waiver of compliance for undue hardship for a period not to exceed 12 months. The bill requires any carrier or its pharmacy benefits manager to provide real-time cost information data to enrollees and contracted providers for a covered prescription drug, including any cost-sharing requirement or prior authorization requirements, and to ensure that the data is accurate. The bill requires that such cost information data is available to the provider in a format that a provider can access and understand. The bill requires the State Corporation Commission's Bureau of Insurance (the Bureau) to, in coordination with the Secretary of Health and Human Resources, establish a work group to evaluate and make recommendations to modify the process for prior authorization for drug benefits in order to maximize efficiency and minimize delays that include a single standardized process and any recommendations for necessary statutory or regulatory changes. The bill requires the work group to include relevant stakeholders, including representatives from the Virginia Association of Health Plans, the Medical Society of Virginia, the National Council for Prescription Drug Programs, the Virginia Pharmacists Association, and the Virginia Hospital and Healthcare Association, and other parties with an interest in the underlying technology. The bill requires the work group to report its findings and recommendations to the Chairmen of the Senate Committee on Commerce and Labor and the House Committee on Commerce and Energy by November 1, 2022. The provisions of the bill other than the requirement for the Bureau to establish

the work group will not become effective unless reenacted by the 2023 Session of the General Assembly.

- **Living organ donors; discrimination prohibited.** HB 421/SB 271 amends and reenacts § 38.2-508 of the Code, relating to insurance; discrimination based on status as living organ donor prohibited. This bill prohibits any person from refusing to insure, refusing to continue to insure, or limiting the amount or extent of life insurance, disability insurance, or long-term care insurance coverage available to an individual or to charge an individual a different rate for the same coverage based solely and without any additional actuarial risks upon the status of such individual as a living organ donor. **The provisions of the bill apply to such insurance plans that are entered into, amended, extended, or renewed on or after January 1, 2023.**

- **Qualified health plans; state-mandated health benefits.** HB 431/SB 449 amends and reenacts § 38.2-6506 of the Code, relating to qualified health plans; essential health benefits; state-mandated health benefits. This bill authorizes a qualified health plan offered on the Virginia Health Benefit Exchange to provide state-mandated health benefits that are not provided in the essential health benefits package. Under current law, qualified health plans are prohibited from providing such state-mandated health benefits.

- **Health insurance; tobacco surcharge.** HB 675/SB 422 amends and reenacts § 38.2-3447 of the Code, relating to health insurance; tobacco surcharge. This bill eliminates the authority of a health carrier to vary its premium rate based on tobacco use. Under current law, a health carrier may charge premium rates up to 1.5 times higher for a tobacco user than for a nonuser. **The provisions of the bill shall apply to health benefit plans providing individual or small group health insurance coverage beginning on January 1, 2023.**

- **Health insurance; association health plan for real estate salespersons.** HB 768/SB 335 amends and reenacts § 38.2-3521.1 of the Code, relating to health insurance; association health plan for real estate salespersons. This bill provides that a licensed insurer may issue a policy of group accident and sickness insurance to an association of real estate salespersons, 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. All members of the association must be eligible for coverage and membership, membership may not be conditioned on any health status-related factor, coverage must be available to all members regardless of health status, the association may not make health insurance coverage offered through the association available other than in connection with a member of the association, and premiums for the policy must be paid from funds contributed by the association or by employer members. The bill requires that the association have at least 25,000 members, be organized and maintained in good faith for purposes other than that or obtaining insurance, have been in active existence for at least 5 years, and have a

constitution and bylaws that provide for holding regular meetings at least annually and member voting privileges. Any such policy will be considered a large group market plan, subject to the Patient Protection and Affordable Care Act, and offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan. Insurers must treat all members enrolled in coverage under the policy as a single risk pool; set premiums on the basis of the collective group experience; and not vary premiums by age, gender, or health status.

- **Health insurance; provider credentialing; receipt of application.** HB 773/SB 427 amends and reenacts § 38.2-3407.10:1 of the Code, relating to health insurance; provider credentialing; receipt of application. This bill requires the protocols and procedures for the reimbursement of new provider applicants that are established by a carrier that credentials providers in its network to require that the carrier provide recognition or notification of receipt of such applicant's credentialing application electronically or by mail.

- **Commonwealth Health Reinsurance Program; federal risk adjustment program.** HB 842/SB 338 amends and reenacts §§ 38.2-6600 and 38.2-6602 of the Code, relating to the Commonwealth Health Reinsurance Program; federal risk adjustment program. This bill eliminates the requirement that the State Corporation Commission consider transfers made under the federal risk adjustment program to eliminate double reimbursement for high-cost cases as a factor when establishing payment parameters for the benefit year under the Commonwealth Health Reinsurance Program. The bill also eliminates the requirement that the Commission factor in transfers received for an enrolled individual under the federal risk adjustment program when calculating each reinsurance payment based on an eligible carrier's incurred claims costs for a covered person's benefits in the applicable benefit year.

- **Group health benefit plans; bona fide associations; formation of benefits consortium.** HB 884/SB 195 amends and reenacts §§ 38.2-3420 and 38.2-3431 of the Code and to amend the Code by adding in Title 59.1 a chapter numbered 55, relating to group health benefit plans; sponsoring associations; formation of benefits consortium. This bill provides that certain trusts constitute a benefits consortium and are authorized to sell health benefit plans to members of a sponsoring association that has been formed and maintained in good faith for purposes other than obtaining or providing health benefits, does not condition membership in the association on any health status-related factor, makes any health benefit plan available to all members, does not make the plan available to anyone who is not a member of the organization, operates as a nonprofit, and has been in existence for at least 5 years. Any health plan issued by a self-funded multiple employer welfare arrangement (MEWA) that covers one or more employees must provide essential health benefits and cost-sharing requirements, offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan, may not limit or exclude coverage by imposing a preexisting condition exclusion on an individual, may not establish discriminatory rules based on health status

related to eligibility or premium or contribution requirements as imposed on health carriers, must meet the renewability standards for health insurance issuers, establish base rated formed a sound, modified community rating methodology, and utilize each employer member's specific risk profile to determine premiums by actuarially adjusting above or below established base rates to reduce the adverse impact on any specific employer member's premiums. This bill also prohibits a self-funded MEWA from issuing health benefit plans in the Commonwealth until it has obtained a license pursuant to regulations promulgated by the State Corporation Commission. The Commission may adopt regulations applicable to self-funded MEWAs.

- **Health insurance; coverage for prosthetic devices.** HB 925/SB 405 amends the Code by adding a section 48.2-3418.15:1, relating to health insurance; coverage for prosthetic devices. This bill requires health insurers, corporations providing health care coverage subscription contracts, health maintenance organizations, and the Commonwealth's Medicaid program to provide coverage for medically necessary prosthetic devices, including myoelectric, biomechanical, or microprocessor-controlled prosthetic devices. The provisions of the bill apply only in the large group markets. **The provisions of the bill apply to any policies issued or delivered on and after January 1, 2023.**

- **Health insurance; calculation of enrollee's contribution; high deductible health plan.** HB 1081/SB 433 amends and reenacts § 38.2-3407.20 of the Code, relating to health insurance; calculation of enrollee's contribution; high deductible health plan. This bill provides that if the application of the requirement that a carrier, when calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, include any amounts paid by the enrollee or paid on behalf of the enrollee by another person results in a health plan's ineligibility to qualify as a Health Savings Account-qualified High Deductible Health Plan under the federal Internal Revenue Code, then such requirement shall not apply to such health plan with respect to the deductible of such health plan until the enrollee has satisfied the minimum deductible required by the federal Internal Revenue Code. The bill provides such limitation does not apply with respect to items or services that are considered preventive care.

- **Health insurance; discrimination prohibited against covered entities and contract pharmacies.** HB 1162 amends and reenacts §§ 38.2-3465 and 38.2-3467 of the Code, relating to health insurance; discrimination prohibited against covered entities and contract pharmacies. This bill prohibits carriers and pharmacy benefits managers from discriminating in the requirements, exclusions, terms, or other conditions imposed on a covered entity or contract pharmacy on the basis that the entity or pharmacy is operating under the 340B Program of the federal Public Health Service Act. Such prohibition does not apply to drugs with an annual estimated per-patient cost exceeding $250,000 or prohibit the identification of a 340B reimbursement request. The bill also prohibits a carrier or

pharmacy benefits manager from interfering in a covered individual's right to choose a contract pharmacy or covered entity.

- **Preneed funeral contracts; emergency.** HB 1269 amends and reenacts §§ 38.2-3100.3 and 54.1-2820 of the Code, relating to preneed funeral contracts; emergency. This bill removes the requirement that if a life insurance or annuity contract is used to fund a preneed funeral contract, the life insurance or annuity contract must provide either that the face value thereof shall be adjusted annually by a factor equal to the annualized Consumer Price Index as published by the Bureau of Labor Statistics of the United States Department of Labor, or a benefit payable at death under such contract that will equal or exceed the sum of all premiums paid for such contract plus interest or dividends, which for the first 15 years shall be compounded annually at a rate of at least five percent. The bill also removes the requirement that interest or dividends continue to be paid after 15 years. The bill provides that for any life insurance or annuity contract that is used to fund a preneed funeral contract, the face amount of any life insurance policy shall not be decreased over the life of such policy except for life insurance policies that have lapsed due to the nonpayment of premiums or have gone to a nonforfeiture option that lowers the amount as allowed for in the provisions of the policy.

- **Accident and sickness insurance; minimum standards.** SB 337 amends and reenacts §§ 38.2-3516 through 38.2-3519 of the Code, relating to accident and sickness insurance; minimum standards. This bill authorizes the State Corporation Commission to issue rules and regulations related to accident and sickness insurance minimum standards and excepted benefits and provides that the purpose of such rules and regulations is to establish (i) the minimum standards for filing of policy forms for individual and small group health benefit plans, (ii) the minimum standards, terms, and coverages for individual and group accident and sickness policies known as excepted benefits, and (iii) the minimum standards for short-term limited-duration insurance. The bill directs the Commission to ensure that such standards are simple and understandable and are not misleading or unreasonably confusing, and that the sale of such policies provides for full disclosure.

- **Pharmacy benefits managers; frequency of required report.** SB 359 amends and reenacts § 38.2-3468 of the Code, relating to pharmacy benefits managers; frequency of required report. This bill changes the frequency of which a carrier or its pharmacy benefits manager is required to report certain information to the Commissioner of Insurance. The bill provides that the report is to be filed quarterly through the period ending December 31, 2022, and is to be filed by March 31 of each year on a calendar year basis thereafter. Under current law, the report is required quarterly indefinitely.

- **Credit life insurance and credit accident and sickness insurance; adjustment of rates; requirement for hearing.** SB 383 amends and reenacts § 38.2-3730 of the Code, relating to credit life insurance and credit accident and sickness insurance; adjustment of rates;

requirement for hearing. This bill removes the requirement that the State Corporation Commission conduct a hearing prior to determining the actual loss ratio for each form of insurance and adjusting the prima facie rates. Under the bills after the Commission has determined the actual loss ratio and prima facie rates, it will provide notice of such ratio and rates and provide an opportunity for a hearing.

- **Health insurance; coverage for mental health and substance use disorders; report.** SB 434 amends and reenacts § 38.2-3412.1 of the Code, relating to health insurance; coverage for mental health and substance use disorders; report. This bill requires the State Corporation Commission's Bureau of Insurance, in its report regarding denied claims, complaints, appeals, and network adequacy involving mental health and substance abuse disorder coverage, to include a summary of certain comparative analyses from health carriers related to mental health parity and an explanation of whether the analyses were considered compliant, and any corrective actions required of the health carrier by the Bureau. The bill also changes the annual deadline for such report from September 1 to November 1.

- **Board of Funeral Directors and Embalmers; life insurance or annuity preneed funeral contract requirements.** SB 679 amends and reenacts §§ 38.2-3100.3 and 54.1-2820 of the Code, relating to preneed funeral contracts. This bill provides that the face amount of any life insurance policy issued to fund a preneed funeral contract shall not be decreased over the life of the insurance policy except where such policies have lapsed due to nonpayment of premiums or have gone to a nonforfeiture option that lowers the face amount as allowed for in the provisions of the policy.

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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 2022. If you have any questions or would like additional information, please contact Scott Sorkin at ssorkin@blandsorkin.com.