Common Problems Identified by the Bureau of Insurance - Life and Health Market Conduct Section

The following information is provided to advise insurers of the statutes and regulations that are frequently cited during a market conduct examination or other regulatory action conducted by the Life and Health Market Conduct Section. The purpose of this document is to highlight potential compliance concerns so insurers can proactively address them.

This list is not all-inclusive, and companies should continue to review Title 38.2 of the Code of Virginia (the Code), appropriate chapters of the Virginia Administrative Code (VAC), and the Bureau's administrative letters and guidance documents on the Bureau's webpage to ensure compliance.

The information provided is organized by

1. Areas of review
2. Topics of interest
3. Bills passed in recent sessions of the General Assembly of Virginia

Examinations and other regulatory actions taken by the Market Conduct Section of the Bureau are conducted under the authority of Section 38.2-1317.1 of the Code and are posted to the Bureau's website upon finalization.

Any questions should be directed to:

Commonwealth of Virginia
State Corporation Commission
Bureau of Insurance
Market Conduct Section (Life and Health)
(804) 371-9532
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1) AREAS OF REVIEW

➢ ADVERTISING/MARKETING COMMUNICATIONS

Life and Annuities Advertising

- Insurer did not maintain a complete file of advertisements of its individual and group life and annuity policies, indicating the manner and extent of distribution and the form number of any policy referred to in any advertisement, for five years after discontinuance of use or publication. **14 VAC 5-41-150 C**

  Tip: A listing of the insurer's advertising is required for review during an exam.

- Insurer did not maintain a system of control over the method of dissemination, content, and form of all advertisements of its life and annuity policies. **14 VAC 5-41-150 B**

  Tip: Advertisements are the insurer's responsibility, including those created by third parties or agents, and are subject to this regulation.

- Insurer presented required disclosure information in an ambiguous fashion or in a way that minimized, rendered obscure, or intermingled with the text of an advertisement, so as to confuse or mislead. **14 VAC 5-41-40 A**

  Tip: Insurers must ensure that disclosures in advertisements are obvious and noticeable.

- Insurer did not provide disclosures of equal prominence and juxtaposition to the effect that issuance of a policy is dependent upon answers to health questions contained in an application for life insurance, if an advertisement uses the terms "nonmedical," "no medical examination required," or similar terms where issue was not guaranteed. **14 VAC 5-41-40 B**

- Insurer included figures, dollar amounts, or statistical information in an advertisement that did not accurately reflect recent and relevant facts and their source. **14 VAC 5-41-40 C**

- Insurer's advertisement stated or implied that the payment or amount of nonguaranteed policy elements are guaranteed. **14 VAC 5-41-60 B**

  Tip: Insurers must ensure that if nonguaranteed policy elements are illustrated in their advertisements:
  - *they are based on the insurer's current scale, and*
  - *the illustration contains a prominent statement to the effect that the nonguaranteed policy elements are not to be construed as guarantees of amounts to be paid in the future.*

- Insurer did not prohibit the use of the phrases "affordable," "inexpensive," "low cost" or similar terms in its advertisements for a policy marketed by direct response techniques or for a life policy containing graded or modified benefits, when the policy being advertised was guaranteed issue. **14 VAC 5-41-80 B**

Accident and Sickness Advertising

- Insurer did not maintain a complete file of advertisements of its individual and group accident and sickness policies, indicating the manner and extent of distribution and the form number of any policy advertised, for the longer of four years or until the filing of the next regular report on examination. **14 VAC 5-90-170 A**

  Tip: A listing of the insurer's advertising is required for review during an exam.

- Insurer did not maintain a system of control over the content, form, and method of dissemination of all advertisements of its accident and sickness insurance policies. **14 VAC 5-90-20 B**

  Tip: Advertisements are the insurer's responsibility, including those created by third parties or agents, and are subject to this regulation.

- Insurer did not ensure the format and content of an advertisement of an accident or sickness insurance policy was sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. **14 VAC 5-90-50 A**
- Insurer did not ensure advertisements were truthful and not misleading in fact or in implication or omit words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology. **14 VAC 5-90-50 B**
- Insurer did not include in an invitation to inquire, a provision in the following or substantially similar form: "This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [write] your insurance agent or the company [whichever is applicable]." **14 VAC 5-90-55 A**
- Insurer did not include prominent required disclaimers about benefit exceptions and reductions and limitations in an invitation to inquire that included rate information. **14 VAC 5-90-55 B**
- Insurer did not prevent the omission of information or the use of words, phrases, statements, references or illustrations if the omission of the information or use of the words, phrases, statements, references or illustrations had the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. **14 VAC 5-90-60 A 1**

  Tip: Insurers must include information necessary for the purchaser of the advertised policy to properly discern the nature, benefits, losses covered and premium payable.

- Insurer used words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases in a manner that exaggerated a benefit beyond the terms of the policy. **14 VAC 5-90-60 A 2**
- Insurer did not disclose exceptions, reductions and limitations affecting basic provisions of the policy in an advertisement when referring to a dollar amount, a

period of time for which any benefit is payable, the cost of the policy, a specific policy benefit, or the loss for which a benefit is payable so as not to mislead or deceive. **14 VAC 5-90-60 B 3**

Tip: If an advertisement includes a specific policy benefit, the insurer must also include a clear explanation of the pertinent limitations and exclusions associated with that benefit.

- Insurer did not use current and relevant facts in an advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy. **14 VAC 5-90-90 A**
- Insurer did not identify the source of statistics used in an advertisement. **14 VAC 5-90-90 C**
- Insurer did not state in the advertisement the name of the actual insurer, the form number or numbers of the policies advertised, and the form number of any application on an invitation to contract. **14 VAC 5-90-130 A**
- Insurer used a trade name, insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device on an invitation to contract, which without disclosing the name of the actual insurer had the capacity and tendency to mislead or deceive as to the true identity of the insurer. **14 VAC 5-90-130 A**
- Insurer used statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business, or used a recommendation by a commercial rating system without clearly indicating the purpose of the recommendation, the name and a description of the entity through which the rating is obtained, and the limitations of the scope and extent of the recommendation, in its advertisements. **14 VAC 5-90-160**

  Tip: Any reference to years in business or size of a provider network must pertain to the specific licensed insurer that is advertising the product(s) that it offers and not to its parent company or affiliated insurer.
- Insurer made, issued, circulated, caused or knowingly allowed to be made, issued, or circulated, an estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresented the benefits, advantages, conditions, or terms of an insurance policy. **Section 38.2-502 (1) of the Code**
- Insurer made, published, disseminated, circulated, or placed before the public, or caused or knowingly allowed, directly or indirectly, an advertisement relating to (i) the business of insurance or (ii) any person in the conduct of his insurance business, which is untrue, deceptive or misleading. **Section 38.2-503 of the Code**
- An HMO insurer or its representative caused or knowingly permitted the use of an advertisement or solicitation that was untrue or misleading or any form of evidence of coverage that was deceptive. **Section 38.2-4312 A of the Code**

➢ PROVIDER CONTRACTS

Tip: Each carrier is responsible for ensuring that every contract with a provider contains each of the provisions required by the Code in their entirety and that claims are processed in accordance with these terms.

- A provider contract did not require the carrier to pay any claim within 40 days of receipt of the claim where the obligation is reasonably clear due to the specific information available for review, as well as maintain a record of the date of receipt of the claim. **Section 38.2-3407.15 B 1 of the Code**

  Tip: An insurer must pay a claim within 40 days of receipt unless:
  - *the claim is determined not to be a clean claim, or*
  - *the claim was submitted fraudulently.*

- A provider contract did not require the carrier, within 30 days after receipt of a claim, to request electronically or in writing the information required to process and pay the claim. **Section 38.2-3407.15 B 2 of the Code**

- A provider contract did not require the carrier to pay any interest owing or accruing on a claim, and that such interest be paid without necessity of demand at the time the claim is paid or within 60 days thereafter.
  Section 38.2-3407.15 B 3 of the Code

  Tip: Any interest owed on a claim must be paid at the time of claim payment or within 60 days. If the carrier takes longer than 15 working days, or 30 calendar days for HMOs, to pay a claim, interest is due.

- A provider contract did not require the carrier to confirm in advance during normal business hours whether the health care services to be provided are medically necessary and a covered benefit, as well as provide and disclose all other information required by this subsection. **Section 38.2-3407.15 B 4 (a) of the Code**

- A provider contract did not require the carrier to make available to providers access to all such policies which apply to the particular provider or to particular health care services identified by the provider within 10 business days of receipt of a request. **Section 38.2-3407.15 B 4 (b) of the Code**

- A provider contract did not require the carrier to pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance that the health care services are medically necessary and a covered benefit, unless the documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized. **Section 38.2-3407.15 B 5 (a) of the Code**

- A provider contract did not require the carrier to pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance that the health care services are medically necessary and a covered benefit, unless the carrier's refusal is because:
  - (i) another payor is responsible for the payment,
  - (ii) the provider has already been paid for the health care services identified on the claim,

- (iii) the claim was submitted fraudulently, or the authorization was based on erroneous information provided to the carrier, provider, enrollee, or other person not related to the carrier, or
- (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

Section 38.2-3407.15 B 5 (b) of the Code

- A provider contract did not require the carrier to pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance that the health care services are medically necessary and a covered benefit, unless it is determined during the post-service claims process that the claim was submitted fraudulently. **Section 38.2-3407.15 B 5 (c) of the Code**

- A provider contract did not require the carrier, in the case of an invasive or surgical procedure, to pay a claim if the carrier has previously authorized a health care service as medically necessary, and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, provided the additional procedures were:
  - (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan
  - (ii) appropriately coded consistent with the procedure actually performed, and
  - (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

  Section 38.2-3407.15 B 6 of the Code

- A provider contract did not require the carrier to refrain from imposing any retroactive denial of a previously paid claim, as defined in § 38.2-3407.15, unless the carrier has provided the reason for the retroactive denial and:

  (i) the original claim was submitted fraudulently,

  (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or

  (iii) the time elapsed since the date of the payment of the original challenged claim does not exceed the lesser of:

  (a) 12 months or

  (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided.

  In addition, the carrier will be required to notify a provider at least 30 days in advance of any retroactive denial of a claim.

  Section 38.2-3407.15 B 7 of the Code

- A provider contract did not require the carrier to refrain from imposing any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund

is sought, with a written explanation of why the claim is being retroactively adjusted. **Section 38.2-3407.15 B 8 of the Code**

Tip: Carriers must not impose retroactive denial of payment or seek refund of a previously paid claim unless a written notice, specifying the impacted claims and the reasons for the retroactive adjustment, is provided at least 30 days prior to the actual retroactive denial.

- A provider contract did not include at the time it was presented to the provider for execution:
  (i) the fee schedule, reimbursement policy, or statement as to how claims are calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis, and
  (ii) all material addenda, schedules, and exhibits and any policies applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.
  Section 38.2-3407.15 B 9 of the Code

- A provider contract did not require that any amendment to the contract (or to any addenda, schedule, exhibit or policy thereto) applicable to the provider (or to the range of health care services reasonably expected to be delivered by the provider) shall be effective unless the carrier provides to the provider any proposed amendment (or proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider fails to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract. **Section 38.2-3407.15 B 10 of the Code**

- A provider contract did not require that in the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider. **Section 38.2-3407.15 B 11 of the Code**

- A provider contract did not require that the carrier establish, in writing, a claims dispute mechanism and make this information available to providers.
  Section 38.2-3407.15 B 12 of the Code

- A provider contract between a carrier and a participating health care provider with prescriptive authority did not require the carrier to accept prior authorization requests delivered from e-prescribing systems, electronic health record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards.
  Section 38.2-3407.15:2 B 1 of the Code

- A provider contract between a carrier and a participating health care provider with prescriptive authority did not require that the carrier communicate to the prescriber within 24 hours, including weekend hours, of submission of an urgent prior authorization request to the carrier that the request is approved, denied, or requires supplementation. **Section 38.2-3407.15:2 B 2 of the Code**

Tip: Provider contracts must require that carriers respond to urgent prior authorization requests with an approval, denial, or a request for additional required information within 24 hours of the submission of the request.

- A provider contract between a carrier and a participating health care provider with prescriptive authority did not require that the carrier communicate to the prescriber, or his designee, within two business days of an authorization request, that the request is approved, denied, or requires supplementation.
  Section 38.2-3407.15:2 B 3 of the Code
- A provider contract between a carrier and a participating health care provider with prescriptive authority did not require that the carrier communicate to the prescriber, within two business days of submission of a supplementation from the prescriber or his designee, that the request is approved or denied.
  Section 38.2-3407.15:2 B 4 of the Code
- A provider contract between a carrier and a participating health care provider with prescriptive authority did not require that if the prior authorization request is denied, the carrier communicate to the prescriber or his designee, within the timeframes established by subdivision 3 or 4, as applicable, the reasons for the denial. **Section 38.2-3407.15:2 B 5 of the Code**

  Tip: Provider contracts must require that the carrier provide reasons for denial of a prior authorization request within two business days.
- A provider contract between a carrier and a participating health care provider with prescriptive authority did not require that prior authorization approved by another carrier be honored, upon receipt from the prescriber of a record demonstrating the previous carrier's prior authorization approval of the previous carrier's coverage of such drug, at least for the initial 30 days of a member's prescription drug benefit coverage under a new health plan, subject to the provisions of the new carrier's evidence of coverage. **Section 38.2-3407.15:2 B 6 of the Code**

  Tip: Provider contracts must require that, if provided with the proper documentation, carriers honor prior authorizations that were approved by the previous carrier for at least the initial 30 days of the new coverage.
- A provider contract between a carrier and a participating health care provider with prescriptive authority did not require that a tracking system be used by the carrier for all prior authorization requests and that the identification information be provided to the prescriber or his designee, upon the carrier's response to the prior authorization request. **Section 38.2-3407.15:2 B 7 of the Code**
- A provider contract between a carrier and a participating health care provider with prescriptive authority did not require that the following be available through one central location on the carrier's website and that such information be updated by the carrier within seven days of approved changes:
  - carrier's prescription drug formularies,
  - all drug benefits subject to prior authorization by the carrier,
  - all the carrier's prior authorization procedures, and
  - all prior authorization request forms accepted by the carrier

  Section 38.2-3407.15:2 B 8 of the Code

- An HMO provider contract did not include a "hold harmless" clause that reads essentially as set forth in this subsection. **Section 38.2-5805 C 9 of the Code**

  Tip: Carriers must ensure the entire "hold harmless" provision is contained in their provider contracts and that it is essentially the same as what is included in this subsection. If a carrier chooses to use different wording, it must be approved by the Commission and cannot be any less favorable to the covered persons.

- A contract, between an intermediary and the health care providers or between the HMO health carrier on behalf of the MCHIP and an intermediary organization, did not include the "hold harmless" clause amended to include nonpayment by the plan, the HMO health carrier and the intermediary organization. **Section 38.2-5805 C 10 of the Code**

The following two sections of the Code are not required to be in the provider contracts, but carriers are responsible for ensuring that they comply with the requirements.

- A health carrier did not maintain a complete file of health care provider contracts for a minimum of five years after the contract expiration.
  Section 38.2-5802 C of the Code
- An HMO did not maintain a complete file of contracts with their intermediary organizations for a minimum of five years after the contract expiration. **Section 38.2-5805 C 8 of the Code**

  Tip: Carriers must be able to provide the examiners with a copy of the entire contract which was in effect during the exam time frame between:
  - *the carrier and the intermediary organization, and*
  - *the intermediary organization and the health care providers*

AGENTS

- An insurer did not verify the licensing and appointment of agents before payment of commissions or other valuable consideration. **Section 38.2-1812 A of the Code**
- An insurer permitted a person to act as an agent of the insurer without first obtaining a license. **Section 38.2-1822 A of the Code**

  Tip: Insurers must ensure that those involved in insurance transactions and who receive compensation are licensed and appointed.

- An insurer accepted applications for insurance coverage from an unappointed agent and did not file a notice of appointment with the Commission within 30 calendar days of the date of execution of the first insurance application or policy submitted by the licensed but not yet appointed agent.
  Section 38.2-1833 A 1 of the Code
- An insurer, following termination of the appointment of an agent, did not notify the agent of their termination within five calendar days and the Commission within 30 calendar days. **Section 38.2-1834 D of the Code**

➢ UNDERWRITING, UNFAIR DISCRIMINATION, INSURANCE INFORMATION AND PRIVACY PROTECTION

Form Filings

- An insurer issued or issued for delivery a policy, services plan, contract, or certificate in Virginia that was not filed with the Commission. An insurer did not ensure that the rate manual showing rates, rules, and classification of risks applicable to an accident and sickness policy had been filed with the Commission. **Section 38.2-316 A of the Code**
- An insurer attached an application, rider or endorsement form that was not filed with the Commission. An insurer used an individual certificate or enrollment form in connection with a group life insurance policy, group accident and sickness insurance policy, group annuity contract, or group variable annuity contract that was not filed with the Commission. **Section 38.2-316 B of the Code**
- An insurer did not file and gain approval of accident and sickness premium rates for health benefit plans in the individual and small group markets before marketing and selling these plans. **Section 38.2-316.1 B of the Code**
- An insurer delivered or issued for delivery policies, contracts, or certificates, or used applications, enrollment forms, riders, or endorsements in connection with policies, contracts, or certificates, that were not approved in writing by the Commission. **Section 38.2-316 C 1 of the Code**

  Tip: Insurers must ensure that all policy forms and rates have been filed with and approved by the Commission, as required, before issuance or use in the state of Virginia.

  Tip: Forms cannot be issued that have been altered from the final format in which they were filed and approved.
- An insurer issuing accident and sickness coverage did not file its explanation of benefits forms for approval. **Section 38.2-3407.4 A of the Code**
- A form number did not appear in the lower left-hand corner of the first page of each form. **14 VAC 5-101-60 1**
- A form was not submitted in the final form in which it was to be marketed or issued, or was not sufficiently completed in "John Doe" fashion to indicate how it was intended to be used. **14 VAC 5-101-60 5**

  Tip: The form number must be included on an issued form and no changes, beyond the variability indicated in the filing of an approved form, can be made on the issued form.
- A form that is to be used in an electronic version was not filed in a format that matches the electronic version exactly. **14 VAC 5-101-60 6**

Adverse Underwriting

- An insurer did not provide the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision, as defined in Administrative Letter 2015-07 (see additional below), in writing or advise such person that upon written request he may receive the specific reason or reasons in writing. **Section 38.2-610 A 1 of the Code**

  Tip: Upon request, insurers must inform individuals who received an adverse underwriting decision of the reasons why that decision was made.

  Note**:** For further guidance as to what constitutes an Adverse Underwriting Decision under Virginia Law, and to review a prototype AUD Notice, please refer to **Administrative Letter 2015-07**.

Insurance Information & Privacy Protection

- An insurer did not provide the applicant, policyholder, or individual proposed for coverage with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code.
  Section 38.2-610 A 2 of the Code

➢ PREMIUM NOTICES

- An insurer did not provide prior written notice of the intent to increase the annual premium by more than 35 percent for proposed renewal of coverage of individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage; individual or group accident and sickness subscription contracts; or a health care plan provided by a health maintenance organization. **Section 38.2-3407.14 A of the Code**
- A health carrier did not provide, in conjunction with the proposed renewal of individual health insurance coverage, notice of intent to increase the annual premium charge for coverage or any required deductible.
  Section 38.2-3407.14 B of the Code
- An insurer did not provide a written notice at least 60 days prior to the proposed renewal of coverage under any plan described in subsection A and at least 75 days prior to the proposed renewal of individual health insurance coverage described in subsection B. **Section 38.2-3407.14 C of the Code**
- A long-term care insurer did not provide required premium rate or rate schedule disclosures as required by this section. **14 VAC 5-200-75**
- A long-term care insurer did not provide notice, with all information required by this section, of an upcoming premium rate schedule increase to all policyholders or

certificate holders, if applicable, at least 75 days prior to the premium rate schedule increase, as well as filing the notice with the commission. **14 VAC 5-200-75 D**

- An insurer did not follow the Company's established premium notice procedures.

➢ CANCELLATIONS/NON-RENEWALS

- An insurer did not provide to an employer, who provides employee coverage, a written notice of termination at least 15 days before termination of coverage due to non-payment of premium. **Section 38.2-3542 C of the Code**

  Tip: The insurer must include the specific date of termination in the notice, and this date must be at least fifteen days after the date of the notice. The effective date of the termination cannot be prior to the specific date of termination provided in the notice.

- A long-term care insurer did not provide notice before lapse or termination to the policy holder and, if elected, a designated person, or did not provide notice of the right to change a designated person once every two years. **14 VAC 5-200-65 A 1**

  Tip: At least once every two years, the insurer shall notify the insured in writing of the right to change their designated person for notification of lapses.

- A long-term care insurer did not provide notice to the insured and to those persons designated in subdivision 1 at least 30 days before the effective date of the lapse or termination and in accordance with the requirements of the remainder of this section. **14 VAC 5-200-65 A 3**

- A long-term care insurer did not provide a provision for reinstatement of coverage in the event of lapse if the insurer receives proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. **14 VAC 5-200-65 B**

➢ COMPLAINTS, APPEALS AND EXTERNAL REVIEW

Complaint System

- An insurer did not maintain a complete record of all complaints received in the last five years, including the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, and the time it took to process each complaint. **Section 38.2-511 of the Code**

- An insurer did not properly maintain an established complaint system approved by the Commission. **Section 38.2-5804 A of the Code**

  Tip: An insurer must follow their approved complaint system when handling each complaint received, including sending notices to the complainant within set timeframes.

- An HMO did not maintain an established complaint system approved by the Commission. **14 VAC 5-211-150 A**
- An insurer did not maintain written complaints for 5 years. **Section 38.2-5804 A 1 of the Code**
- An insurer did not provide compliant forms and procedures to covered persons in the prescribed manner. **Section 38.2-5804 A 2 of the Code**

Appeals

- An insurer did not establish an internal appeal process, including urgent appeals, to review adverse determinations, adverse benefit determinations, or other decisions appealed by a covered person, authorized representative, or provider. **Section 38.2-3558 of the Code**

External Review System

- An insurer did not promptly approve a claim upon notice of reversal of a final adverse determination. **Section 38.2-3561 J of the Code**

  Tip: Carriers must promptly and without delay, approve claims which were previously denied and, after appeal, overturned by an independent review organization.

- An insurer did not include the standard and expedited external review procedures and any forms with the notice of the right to an external review. **Section 38.2-3559 D of the Code**

  Companies should refer to the Explanation of Benefits Notice Requirements for Health Carriers on the Bureau of Insurance website.

➢ CLAIM PRACTICES

- A company, as a general business practice, misrepresented pertinent facts or insurance policy provisions relating to coverages at issue. **Section 38.2-510 A 1 of the Code**
- A company, as a general business practice, did not acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. **Section 38.2-510 A 2 of the Code**
- A company, as a general business practice, did not adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. **Section 38.2-510 A 3 of the Code**
- A company, as a general business practice, did not affirm or deny claims within a reasonable time after proof of loss statements have been completed. **Section 38.2-510 A 5 of the Code**

- A company, as a general business practice, did not provide prompt, fair and equitable settlements of claims in which liability has become reasonably clear. **Section 38.2-510 A 6 of the Code**

- A company, as a general business practice, did not promptly provide a reasonable explanation of the denial of a claim or for the offer of a compromise settlement, with respect to policy provisions or applicable law.
  Section 38.2-510 A 14 of the Code

- A company did not provide to an insured an explanation of benefits which clearly and accurately disclosed the method of benefit calculation and the actual amount paid to the provider of services. **Section 38.2-514 B of the Code**

- A company did not provide an explanation of benefits that accurately and clearly explained the benefits payable under the contract.
  Section 38.2-3407.4 B of the Code

- An HMO allowed the determination of order of benefits to restrict or impede the provision of a covered health care service to an enrollee because the enrollee is entitled to coverage under other policies, contracts, or health care plans. The HMO did not provide or arrange for the service first and then, at its option, seek coordination of benefits with any other health insurance or health care benefits or services that are provided by other policies, contracts, or plans.
  14 VAC 5-211-80 B

  Tip: HMOs must not hold an enrollee liable for the cost of covered services prior to a Coordination of Benefits determination.

- A company, as a general business practice, did not maintain detailed documentation for each claim file to permit reconstruction of the insurer's activities relating to each claim. **14 VAC 5-400-30 C**

  Tip: Insurers shall have claim files maintained, accessible, and available to the Commission for, at a minimum, the current year and the three preceding calendar years.

- An insurer, as a general business practice, did not fully disclose to a first party claimant all pertinent benefits, coverages, or other provisions of an insurance policy under which a claim is presented and document the claim file accordingly. **14 VAC 5-400-40 A**

- An insurer, as a general business practice, did not acknowledge receipt of a claim within 15 calendar days of receipt unless payment was made within such period of time, or if a provider submits a claim, unless payment or denial of the claim is made to the provider within 21 calendar days. **14 VAC 5-400-50 A**

- An insurer, as a general business practice, did not send a written notice to the first party claimant within 45 calendar days from the date of the notification of a first party claim, and every 45 calendar days thereafter if an investigation of a first party claim has not been completed, setting forth the reasons additional time is needed for investigation. **14 VAC 5-400-60 B**

- An insurer, as a general business practice, did not, within 15 days of adequate proof of loss, advise a first party claimant of the acceptance or denial of the claim by the insurer or that additional time was required. **14 VAC 5-400-60 A**

- An insurer, as a general business practice, did not provide a claim denial in writing to a claimant. **14 VAC 5-400-70 A**

  Tip: The claim file must contain a copy of the denial.

- A health insurer, as a general business practice, did not provide a reasonable written explanation of the basis for any claim denial, to include a specific reference to a policy provision, condition, or exclusion, if any. **14 VAC 5-400-70 B**

- A health insurer, as a general business practice, did not offer a fair and reasonable amount, within policy provisions, to a first party claimant, after investigation of the claim where there is no dispute as to coverage or liability. **14 VAC 5-400-70 D**

- An insurer, as a general business practice, did not reasonably pay any claim in accordance with the provisions of the policy. **14 VAC 5-400-70 E**

- An accident and sickness insurer, as a general business practice, did not provide an explanation of benefits to the insured describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss, unless otherwise specified in the policy. **14 VAC 5-400-100 B**

- An insurer, as a general business practice, did not provide, at the insured's request, an electronic or written summary of prescription drug claims which describes amounts covered, amounts denied, and amounts payable by the insured and insurer under the policy. **14 VAC 5-400-100 C**

  Tip: The summary of prescription drug claims must contain details related to claim processing, including information related to approved and denied charges; denial reasons; the insured's copayment, coinsurance, deductible, and out-of-pocket maximum accumulators; the allowable amounts for charges; and the amounts paid by the insurer on the claim.

Interest Payments

- A life insurance and annuity company did not pay interest upon the principal sum at an annual rate of 2-1/2 percent or the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater, either beginning (i) from the date of death on a life insurance policy or annuity contract claim; (ii) from the date of receipt of a completed claim form on a variable annuity contract claim; or (iii) from the date of maturity of an endowment contract to the date of payment. **Section 38.2-3115 B of the Code**

  Tip: This interest requirement applies to proceeds from all policies delivered or issued for delivery in Virginia, regardless of the state where the insured resided at the time of death or where the beneficiary/claimant resides at the time of payment. The location of the insured or beneficiary/claimant is irrelevant when calculating the interest.

- An accident and sickness insurance company did not pay interest on claims from the date of 15 working days after the receipt of proof of loss to the date of claim payment. **Section 38.2-3407.1 B of the Code**

- An HMO did not pay interest on claim proceeds from the date of 30 days from the date the proof of loss is received to the date of claim payment.
  Section 38.2-4306.1 B of the Code

  Tip: Interest owed on accident and sickness or HMO claim proceeds is computed daily at the legal rate of interest, and § 6.2-301 A of the Code indicates that the legal rate of interest is an annual rate of six percent.

2) TOPICS OF INTEREST

The following are specific emerging topics where new legislation exists and in which Market Conduct devotes heightened interest in evaluating the practices of carriers, as the impact on the consumer may be significant. We have also provided links where more information can be found on the Bureau of Insurance website.

Mental Health Parity

Future exams and inquiries will include reviews for compliance with MHPAEA, and guidance on this topic continues to evolve. Resources are available on the BOI website at Virginia SCC - Mental Health / Substance Use Disorder Benefits Parity that describe the requirements. Carriers should familiarize themselves with these documents so they can be prepared to have the necessary documentation available upon request.

Pharmacy Benefit Managers (PBMs)

Legislation effective October 1, 2020, mandates that all PBMs used by carriers be licensed in the Commonwealth, provide periodic reporting and adhere to specific rules relating to advertising, claims, reimbursements for services, network restrictions or adequacy determinations, retaliation for exercising rights and spread pricing. Additional information is available on the BOI website at: https://scc.virginia.gov/pages/Pharmacy-Benefits-Mgmt.

Balance Billing

Legislation effective January 1, 2021, puts restrictions on the balance billing of consumers for certain services, updates specific cost-sharing and EOB notification, requires carriers to make available the names of in-network providers, requires carriers to work with providers on pricing and requires carriers to provide proper notices to consumers of the provisions. Additional information is available on the BOI website at: https://scc.virginia.gov/pages/Balance-Billing-(1)

3) RECENT LEGISLATION

Below are legislative acts approved in Virginia's 2020, 2021 and 2022 General Assembly legislative sessions which primarily apply to Life and Health Market Conduct Exams and other regulatory actions. A brief description of the bill follows with a link to the section (§) of the Code.

Descriptions of changes to the code sections during legislative sessions can be found using the LIS links at the bottom of the page where the code section is displayed.

2022 Legislative Updates

Code Section	Description	Effective Date
§§ 38.2-3408 and 38.2-4221 (revised)	Health carriers; licensed athletic trainers	1/1/2023
§ 38.2-3418.17 (revised)	Health insurance; definition of autism spectrum disorder	7/1/2022
§ 38.2-608 (revised)	Practice of licensed professional counselors	7/1/2022
§ 38.2-508 (revised)	Discrimination based on status as living organ donor prohibited	1/1/2023
§ 38.2-3521.1 (revised)	Health Insurance; association health plan for real estate salespersons	7/1/2022
§ 38.2-3407.10:1 (revised)	Health insurance; provider credentialing, response to electronic application	7/1/2022
§ 38.2-3418.15:1 (revised)	Health insurance; prosthetic devices, large group coverage	1/1/2023
§ 38.2-3407.20 (revised)	Health insurance; calculation of enrollee's contribution to high deductible health HSA	7/1/2022
§ 38.2-107.2	Private Family Leave Insurance; for Life and Annuity Insurers	7/1/2022
§ 38.2-3467	Health Insurance; Discrimination prohibited against covered entities or contract pharmacies	7/1/2022
§ 38.2-3100.3	Preneed Funeral Contracts; Decrease in face amount prohibited	3/9/2022

2021 Legislative Updates

Code Section	Description	Effective Date
§ 38.2-3451 (revised)	Essential health benefits; abortion coverage	7/1/2021
§ 38.2-3418.16 (revised)	Telemedicine	7/1/2021
§ 38.2-3407.15:6, § 38.2-3407.22	Prescription drug price transparency	1/1/2022
§ 38.2-3407.15:2 (revised)	Requirements for Provider Contracts Health insurance; authorization of drug prescribed for the treatment of a mental disorder	7/1/2021

§ 38.2-3407.7, § 38.2-4209.1, § 38.2-4312.1 (revised)	Pharmacies; freedom of choice	7/1/2021
§ 38.2-3407.15 (revised)	Health insurance; provider contracts	7/1/2021

2020 Legislative Updates

Code Section	Description	Effective Date
§ 38.2-3407.15:5	Health insurance; cost-sharing payments for prescription insulin drugs	7/1/2020
§ 38.2-3407.4 (revised)	Health care services; explanation of benefits	7/1/2020
§ 38.2-3407.10:1 (revised)	Health insurance; credentialing; health care providers	7/1/2020
§ 38.2-3418.18	Health insurance; formula and enteral nutrition products	7/1/2020
§ 38.2-3407.21	Health insurance; short-term limited-duration medical plans	7/1/2021
§§ 38.2-3408, 38.2-3412.1, and 38.2-4221 (revised)	Health insurance; clinical nurse specialists	7/1/2020
§ 38.2-3454.1 (revised)	Health benefit plans; special exception	7/1/2020
§§ 38.2-3445.01 - 38.2-3445.07	Balance Billing - Health insurance; payment to out-of-network providers	1/1/2021
§ 38.2-3418.19	Organ, eye, or tissue transplantation; discrimination prohibited	1/1/2021
§§ 38.2-3465 - 38.2-3470	Pharmacy benefits managers; licensure and regulation	10/1/2020
§ 38.2-3449.1	Health insurance; nondiscrimination; gender identity or transgender status	7/1/2020
§ 38.2-3418.17 (revised)	Health insurance; coverage for autism spectrum disorder	1/1/2021
§ 38.2-3438, § 38.2-3442 (revised)	Health insurance; essential health benefits; preventive services	7/1/2020
§ 38.2-3610	Medicare supplement policies for certain individuals under age 65	7/1/2020
§ 38.2-3407.11:4	Disability insurance; childbirth	7/1/2020
§ 38.2-3407.11:5	Health insurance; interhospital transfer for newborn or mother	7/1/2020