BUREAU OF INSURANCE
June 5, 2000

Administrative Letter 2000-8

TO: All Insurers, Health Services Plans, Health Maintenance Organizations (HMOs) and Other Interested Parties

RE: Legislation Enacted by the 2000 Virginia General Assembly

We have attached for your reference staff summaries of certain statutes enacted or amended and re-enacted during the 2000 Session of the Virginia General Assembly. **The effective date of these statutes is July 1, 2000, except as otherwise indicated in this letter.** Each organization to which this letter is being sent should review the attachments carefully and see that notice of these laws is directed to the proper persons, **including appointed representatives**, to ensure that appropriate action is taken to effect compliance with these new legal requirements. Please note that this document is a **summary** of legislation. It is neither a legal review and interpretation nor a full description of the legislative amendments made to insurance-related laws during the 2000 Session. Each organization is responsible for legal review of the statutes pertinent to its operations.

Cordially,

Alfred W. Gross
Commissioner of Insurance

AWG/dpb
Attachment

BUREAU OF INSURANCE
ADMINISTRATIVE LETTER 2000-8

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NOTE: EXCEPT WHERE OTHERWISE INDICATED, ALL BILLS ARE EFFECTIVE JULY 1, 2000

PROPERTY AND CASUALTY BILLS

Chapter 207 (House Bill 398) – EFFECTIVE APRIL 1, 2000

This bill amends § 38.2-5001, the definition of "participating physician," in the Virginia Birth-Related Neurological Injury Compensation Act to include partnerships, corporations, professional corporations, professional limited liability companies, or other entities through which the participating physician practices.

The bill also amends § 8.01-273.1 of the Civil Remedies Title by limiting to participating physicians and hospitals the parties who may make a motion to refer a cause of action to the Workers' Compensation Commission and by requiring that a motion to refer the cause of action to the Workers' Compensation Commission be filed 120 days after the date the party seeking referral files its grounds of defense.

The bill states that the provisions of the act are declarative of existing law.

Chapter 401 (House Bill 453)

This bill adds § 38.2-2125 to the Fire Insurance Policies Chapter. The bill requires insurers that exclude flood coverage under a policy of fire insurance, or a policy of fire insurance in combination with other coverages, to provide a written notice explicitly stating that such coverage is excluded. The notice must further state that information regarding flood insurance is available from the insurance agent or the National Flood Insurance Program. This notice applies to new and renewal policies.

NOTE: The Bureau does not intend to apply the requirement set forth in Chapter 401 to persons licensed as surplus lines brokers or unlicensed insurers approved for the placement of surplus lines coverage pursuant to Chapter 48 of Title 38.2 of the Code.

Chapter 526 (House Bill 716)

This bill amends §§ 38.2-122, 38.2-122.1, 38.2-233 (General Provisions), 38.2-317 (Insurance Policy Provisions), 38.2-415 (Assessments), 38.2-1601 (Property and Casualty Insurance Association), 38.2-1800 (Insurance Agents), 38.2-1902, 38.2-2001,

38.2-2003 (Regulation of Rates), and 52-36 in the Police Title, and adds new sections numbered §§ 38.2-122.2 and 38.2-2006.1 regarding credit property and credit involuntary unemployment insurance (IUI).

The term “credit property insurance” is being added to Chapter 1 of Title 38.2 as a new line of insurance (§ 38.2-122.2). The definition of “credit involuntary unemployment insurance” is being amended in Chapter 1 (§ 38.2-122.1) to allow for the sale of coverage to a debtor who goes on an unpaid leave of absence during which time employment does not terminate. The new provision will allow companies to provide coverage for an unpaid voluntary leave of absence such as family medical leave, jury duty, or active military duty.

Section 38.2-233 is being amended to require that consumers of credit property insurance be given the same disclosures as those required to be given to purchasers of credit involuntary unemployment insurance.

A new provision is being added under subsection F of § 38.2-233 specifying that if coverage is cancelled, insurers must refund any unearned premium on a pro rata basis. The provision is written so that the State Corporation Commission (Commission) may not approve a credit property or credit IUI form unless it contains such language.

Another provision is being added under subsection F of § 38.2-233 giving consumers a ten-day free look period. The Commission may not approve a credit property or credit IUI form unless it contains a notice advising consumers that they have ten days to cancel the policy and receive a full refund.

A new subsection G is being added to § 38.2-233 prohibiting insurers from charging premiums for items not covered under a credit property insurance policy such as finance charges, service fees, delivery charges, taxes, or interest. This is applicable to closed-end credit transactions. Under open-end credit transactions, if premiums are based on amounts paid for finance charges, service fees, delivery charges, taxes, interest, meals, entertainment, or any other item not covered under the credit property insurance policy, insurers will have to advise consumers at least twice a year that they may be paying premiums for items not covered under the policy.

A new subsection I is being added to § 38.2-317 giving the Commission jurisdiction over certificates delivered or issued for delivery in Virginia where the group policy is delivered in another state.

Changes are being made to §§ 38.2-1902 and 38.2-2001 to bring the rates for credit property insurance and credit IUI under the “prior approval” provisions of Chapter 20 rather than the “file and use” provisions of Chapter 19.

A new subsection E is being added to § 38.2-2003 to establish a loss ratio standard for credit property and credit IUI rates. Under the proposal, the Commission may not

approve any rate that falls below this standard. A transition period has been included in the bill which sets the first loss ratio standard at 40% beginning January 1, 2001. In 2003, it goes to 45%; and in 2005, it goes to 50%.

A new section numbered § 38.2-2006.1 is being added to require that credit property and credit IUI rates be filed with the Commission to be approved for use on or after April 1, 2001, April 1, 2003, and April 1, 2005, as set forth in § 38.2-2003.

Key Effective Dates of House Bill No. 716 are as follows:

July 1, 2000

- Companies that are currently writing or intend to write credit property insurance must amend their license to add credit property insurance.
- Credit property and credit involuntary unemployment forms must comply with the provisions contained in the bill:
  (i) currently approved forms must be brought into compliance;
  (ii) new programs must comply; and
  (iii) certificates issued or delivered in Virginia where the group policy is not issued or delivered in Virginia must be filed for approval.
- Companies must comply with the new notice requirements.
- Companies must now certify that their credit property forms (as well as their credit involuntary unemployment forms) achieve a Flesch readability score of at least 40.
- Rates for credit property and credit involuntary unemployment insurance are subject to prior approval rate regulation. This applies to filings which include:
  (i) rate revisions applicable to currently approved programs;
  (ii) rates applicable to new programs (certificates and/or master policies); and
  (iii) rates applicable to certificates issued or delivered in Virginia where the group policy is not issued or delivered in Virginia.

January 1, 2001

The 40% loss ratio standard becomes effective.

April 1, 2001

No rate may be charged after April 1, 2001 unless the rate has been approved by the Commission and complies with the 40% loss ratio standard.

Chapter 529 (House Bill 854)

This bill amends §§ 38.2-231 (General Provisions Chapter), 38.2-2113 (Fire Insurance Policies Chapter), and 38.2-2208 (Liability Insurance Policies Chapter) by permitting

insurers to transmit certain notices to lienholders electronically (i.e., notices of cancellation, refusal to renew, a reduction in coverage, or an increase in rate). This will only be permissible when the insurer and the lienholder agree upon the specifics for transmittal and acknowledgement of notification. The bill also requires the insurer to retain, for at least one year from the date of termination, evidence of transmittal or receipt of the notification.

Chapter 545 (Senate Bill 456)

This bill repeals subsection E of § 38.2-513 in the Unfair Trade Practices Chapter. This subsection required lending institutions, bank holding companies, savings institution holding companies, or subsidiaries or affiliates licensed to sell insurance to give purchasers of insurance ten days to cancel the policy and receive a pro rata refund. This subsection also required certain disclosures to be given to the purchaser such as the cost of the insurance and the right to cancel the insurance and receive a pro rata refund.

The bill also amends subsection A of § 38.2-513 by requiring that any person who lends money or extends credit and who solicits insurance on real or personal property must explain to the borrower in writing that the availability of such loan or extension of credit and the interest rate paid or charged for a loan or an extension of credit may not be conditioned upon the purchase of insurance from such person.

Chapter 548 (Senate Bill 587)

This bill amends § 38.2-317 in the Provisions Relating to Insurance Policies Chapter and adds § 38.2-1903.1 in the Regulation of Rates Chapter to allow for the deregulation of certain lines of commercial insurance. Except for workers' compensation insurance and professional liability insurance rates and forms, and except for commercial automobile insurance forms, the bill allows the rates and forms for a "large commercial risk" to be exempt from the policy form approval and rate filing requirements of Title 38.2 if the large commercial risk meets certain criteria. A large commercial risk must employ or retain a risk manager. A risk manager must have **one** of the following:

- Degree in Risk Management;
- CPCU (Chartered Property and Casualty Underwriter);
- ARM (Associate in Risk Management);
- CRM (Certified Risk Manager);
- FRM (Fellow in Risk Management); or
- Five years of experience in **one** of the following:
    - Risk Financing;

- Claims Administration;
- Loss Prevention; or
- Risk and Insurance Coverage Analysis.

A large commercial risk must also meet **two** of the following criteria:

- Possess a net worth over $10,000,000;
- Generate annual revenues over $25,000,000;
- Employ more than 80 employees (or be a member of an affiliate with over 100 employees);
- Pay annual aggregate nationwide premiums over $100,000 (excluding professional liability and workers' compensation premiums);
- Generate annual budgeted expenditures of at least $10,000,000 (If a not-for-profit organization or public body);
- If a municipality, have a population over 30,000.

Each year, the insurer must get a written certification signed by the risk manager and the CEO stating that the large commercial risk:

- Has a risk manager with the necessary qualifications (and states the qualifications);
- Meets two of the other criteria stated in the law;
- Is aware the policy is not subject to initial regulatory review or approval; and
- Has the necessary expertise to negotiate its own language and rates, and agrees to the use of the exempted rates and forms.

This certification must be retained by the insurer. Each year, the insurer must also give the Commission the number of exempted policyholders and an aggregation of the criteria establishing the exemption.

Chapter 624/718 (Senate Bill 735/House Bill 1271) – EFFECTIVE JANUARY 1, 2001

This bill amends §§ 38.2-1901 (Regulation of Rates Chapter), 65.2-101, and 65.2-801 (Workers' Compensation Act), and adds new sections numbered §§ 38.2-1921.1 and 65.2-803.1. The bill requires professional employer organizations (PEOs) to register with the Workers' Compensation Commission and allows registered PEOs to purchase workers' compensation insurance coverage for workers leased to their client companies.

Under the new law, a PEO may obtain a master workers' compensation insurance policy in its own name covering all of the employees that it leases to its client companies. This provision only applies to PEOs that purchase workers' compensation

insurance through the voluntary market. PEOs that obtain coverage through the assigned risk market are not eligible for these master policy arrangements. Client companies are required to maintain a separate policy covering employees not insured by the PEO's policy.

The new law establishes guidelines for determining the experience rating modification factors to be used. The law allows insurers to conduct periodic audits of PEOs and client companies and also allows insurers to inspect the premises of the client companies. Provisions are also included to ensure that client companies and the Workers' Compensation Commission receive notice whenever coverage is terminated.

The new law requires that anyone who solicits, negotiates, procures, or effects insurance on behalf of a PEO must be licensed as an insurance agent.

The provisions of this bill are effective with respect to any workers' compensation insurance policy issued to or renewed with a PEO on or after January 1, 2001.

Chapter 1038 (House Bill 21)

This bill amends § 38.2-5004.1 in the Virginia Birth-Related Neurological Injury Compensation Act to make the insurance company notification provision apply only to insurers described in § 38.2-5020.1 rather than all insurers. This bill amends the law that was enacted in 1999 requiring insurers and self-insurers to report to the Virginia Birth-Related Neurological Injury Compensation Program any claims which allege a possible birth-related neurological injury. The law will now only require *medical malpractice liability* insurers licensed in the Commonwealth to report these claims rather than *all* insurers licensed in the Commonwealth.

The bill also states that the amendments to § 38.2-5009 enacted in 1990 shall be retroactively effective in all cases arising prior to July 1, 1990, that have been filed on a timely basis and are not yet final. (The 1990 amendments extended coverage to injured infants delivered by a participating physician *or* born at a participating hospital.)

TITLE BILLS

Chapter 549 (Senate Bill 620)

This bill amends §§ 6.1-2.21, 6.1-2.27 (Banking and Finance Title), and 38.2-1810 (Insurance Agents Chapter), and enacts § 6.1-2.23:1 relating to the Consumer Real Estate Settlement Protection Act.

Section 6.1-2.21 has been amended to clarify that a title insurance agent acting in the capacity of a settlement agent must be appointed by a title insurance company licensed in Virginia.

Section 6.1-2.23:1 has been added to prohibit settlement agents from intentionally making materially false or misleading statements or entries on a settlement statement. A good faith estimate of charges indicated as such on the settlement statement shall not be deemed to be a violation.

Section 6.1-2.27 has been amended to allow the appropriate licensing authority to order that restitution be made when there has been a violation of the chapter. It also gives the Commission the authority to order penalties, injunctions, and restitution if a person who does not hold a license from the appropriate licensing authority has violated the chapter.

Section 38.2-1810 has been amended to require that title insurers file a statement with the Commission if the insurer suspects that an appointed title insurance agent has committed an act of larceny with respect to money belonging to an insured or prospective insured or received in connection with performing settlement services.

INSURANCE AGENTS AND CONTINUING EDUCATION BILLS

Chapter 522 (House Bill 455)

This bill amends §§ 38.2-1868.1 through 38.2-1872 in the Continuing Education Article of the Insurance Agents Chapter. The bill clarifies the two dates for the submission of proof of compliance and that the Continuing Education Board (Board) grants full and partial waivers of credit requirements. The bill clarifies that the notice from the Commission prior to license termination may be more than 30 days. The subsection also clarifies that the Board Administrator and Commission have no authority to extend time for the submission of proof of compliance, request of waivers, or additional time to complete courses. Other clarifications include the distinction between notice of impending termination and the 30-day period for correction of records. The bill establishes a reasonable appeal period before license terminations.

The bill also modifies the time for filing an appeal of a Board decision. The agent is required to provide written notice within 45 days following the 30-day period for record correction.

The bill provides that agents wishing to contest the termination of a license by the Commission must adhere to the Commission's Rules of Practice and Procedure and the Rules of the Supreme Court of Virginia.

The bill clarifies that if a property and casualty insurance agent's license is terminated for noncompliance with the article and the agent is licensed as a surplus lines broker, the surplus lines broker's license is also terminated, as is a title settlement agent's license who has a title insurance agent's license terminated for noncompliance, and as is a variable contracts agent's license who has a life and health insurance agent's license terminated for noncompliance.

The bill modifies the penalty provisions imposed on **nonresident** agents who fail to comply with the article. The requirement that nonresidents complete Virginia's pre-licensing education and pre-licensing examination requirements has been removed from the statute, except with respect to agents from states without continuing education requirements or states that are non-reciprocal. Residents of states without continuing education or reciprocity agreements with Virginia will continue to be required to take the Virginia study course and examination if their Virginia license(s) terminate for noncompliance.

The bill permits partial waivers for course credits. That is, licensees who have completed some but not all of the course requirements may apply for waivers of the remaining required hours under certain conditions and for good cause. Requests for full or partial waivers can be submitted to the Board or its administrator by the deadlines set forth in the statute.

The bill expands the circumstances under which **resident** agents who will have attained the age of 65 by the end of a biennium may apply for and be granted an exemption. In addition to the existing exemption if the resident agent has held resident or nonresident Virginia licenses for at least 20 years, the law will now permit an exemption if a resident agent has currently held a Virginia resident license for at least four years by the end of the biennium and held equivalent licenses in other states for sufficient years to make a total of 20 continuous years licensed.

The bill also requires the Board to provide information to the Commission on the final list of agents in compliance with the article 15 days after the appeal period rather than by May 30 following the end of a biennium.

LIFE BILLS

Chapter 173 (House Bill 940)

This bill provides a means of permitting additional benefits for educational loan guarantees to be included with life insurance products.

This is accomplished as follows:

1. Section 38.2-102 in the General Provisions Chapter is amended to add a new subsection B that includes within the definition of "life insurance" additional benefits to provide for educational loans, subject to the provisions of new § 38.2-3113.3.

2. Section 38.2-3113.3 is added to the Life Insurance Chapter to allow educational loan benefits to be included as additional benefits, either as part of the life policy or as a rider or separate agreement. The policy, rider, or separate agreement must state clearly that the loan will be granted provided the covered individual applying for such loan has satisfied the stated qualifications. Loan eligibility qualifications shall not be more restrictive than the following:

- The loan applicant is a covered individual under the life policy.

- The purpose of the loan is to provide funds for a covered individual to attend an institution of higher learning, a trade school, or a technical school age.

- Eligibility may be limited to an age range no less restrictive than age 15-25, subject to continued life insurance coverage of the covered individual during this duration.

- The individual must attend a qualifying institution at least half-time and must maintain an academic record sufficient to demonstrate reasonable progression or advancement.

3. The amount of funds available must be specified in the policy, rider, or separate agreement, and must be limited to an amount not to exceed the actual cost of the school or institution during any given year of attendance. If the amount is to vary by year of attendance, this must be disclosed and a schedule included.

4. The terms of the loan must be clearly stated, and if, in a document other than the policy, the document must be filed with the Commission for review.

5. There is a disclosure requirement under which the individual must be advised of the prudence of obtaining information about educational loans from a variety of sources before making any decision about borrowing funds for financing higher education.

6. The forms, including the policy, rider, or separate agreement, must be filed with and approved by the Commission before they can be used.

7. All advertising material used in the solicitation or promotion of the educational loan feature of a life insurance policy, rider, or separate agreement must be filed with and approved by the Commission before it can be used.

Chapter 193 (Senate Bill 304)

This bill amends § 38.2-305 in the Provisions Relating to Insurance Policies Chapter dealing with the contents of insurance policies. The bill requires life insurance policies and annuity contracts that contain a beneficiary designation that names the spouse of the policy owner to contain a notice titled "Beneficiary Designation May Not Apply in the Event of Annulment or Divorce." The notice must be attached to or incorporated into the front or first page of the contract.

The notice describes the requirements of § 20-111.1, which voids a revocable beneficiary designation for a policy owned by one spouse that names the other spouse beneficiary upon entry of an annulment or divorce decree. The notice provides information about action that can be taken prior to entry of the decree, if the parties desire the beneficiary designation to continue. The parties can (i) change the beneficiary designation to make it irrevocable; (ii) change the ownership of the policy or contract; (iii) execute a separate written statement; or (iv) have the decree contain a provision that the beneficiary provision is not revoked pursuant to § 20-111.1

NOTE: If the insurer elects to comply with this requirement by attaching a separate notice to the front or first page of the contract, such notice must be filed with and approved by the Bureau in accordance with the requirements of § 38.2-316. Further, if the insurer also intends to use the separate notice with new issues of previously approved forms, a listing of those forms, along with the Bureau's approval dates, must be submitted to the Bureau as part of the form submission. If, on the other hand, the insurer intends to comply with this requirement by revising and reprinting previously approved policies to incorporate the notice directly within the text of the front or first page of newly issued policies, the policies will need to be assigned new form numbers and be submitted to the Bureau for approval.

HEALTH BILLS

Chapter 118 (House Bill 574)

This bill amends § 38.2-3411.1 in the Mandated Benefits Article of the Accident and Sickness Insurance Chapter to require the offer of coverage for "child health

supervision services." The bill adds short-term travel or accident only policies and short-term nonrenewable policies of not more than six months to the policies **exempt** from the requirements of the section.

Chapter 136 (House Bill 1014)

This bill amends § 38.2-3430.3 in the Individual Health Insurance Coverage Article of the Accident and Sickness Insurance Chapter to require the guaranteed availability of individual coverage for persons with prior group coverage. The bill exempts applications used for Medicare beneficiaries participating in plans administering

coverage according to state and federal guidelines for predetermined compensation (Medicare + Choice) from requirements imposed to determine eligibility under the Health Insurance Portability and Accountability Act. The bill also amends § 38.2-3432.3 to reduce the length of time that a late enrollee can be excluded from coverage or have a pre-existing limitation applied to 12 months.

Chapter 149 (House Bill 1497)

This bill adds § 38.2-3407.13:1 to the Accident and Sickness Insurance Chapter. The bill applies to insurers issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing subscription contracts; and health maintenance organizations (HMOs) providing health care plans.

Any policy, contract, or plan including certificates or evidences of coverage that contain a coordination of benefits provision must provide written notice to the insured, subscriber, or member as a prominent part of its enrollment materials. The notice must inform the insured, subscriber, or member that if they are covered under another policy, contract, or plan, the other policy, contract, or plan may have primary responsibility for the covered expenses of other family members enrolled with the insured, subscriber, or member. The written notice must describe the conditions under which the other coverage would be primary for dependent children and the method the insured, subscriber, or member can verify which coverage would have primary responsibility for each family member.

The bill is not to be construed to abrogate coordination of benefits provisions, pursuant to § 38.2-3405 B.

Chapter 157 (House Bill 165)

This bill adds § 38.2-3418.12 to the Accident and Sickness Insurance Chapter and amends § 38.2-4319 in the Health Maintenance Organizations (HMOs) Chapter. The bill applies to insurers issuing individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing subscription contracts; and HMOs providing health care plans. The policies, plans, and contracts must include coverage for medically necessary general anesthesia and hospitalization or facility charges in a licensed outpatient surgical facility or hospital. The coverage is for outpatient surgical procedures for dental care for a covered person that the dentist and treating physician determine requires general anesthesia and admission to a hospital/outpatient surgery facility to provide effective, safe dental care if the person is (i) is under the age of five, or (ii) is severely disabled, or (iii) has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental treatment. For

purposes of the section, a determination of medical necessity must include, but not be limited to, consideration of whether the age, physical condition, or mental condition of the covered person requires utilization of general anesthesia and admission to a hospital or surgical facility.

The insurer, corporation, or HMO may require prior authorization in the same manner as for other benefits.

The insurer, corporation, or HMO shall restrict coverage for general anesthesia to providers licensed to provide anesthesia and coverage for facility charges to licensed facilities.

The bill is not to be construed to require coverage for dental care incident to the coverage in the bill.

The bill applies to policies, contracts, or plans delivered, issued for delivery, or renewed in Virginia on and after July 1, 2000.

The bill does not apply to short-term travel, accident only, limited or specified disease policies, or to policies or contracts designed for issuance to persons eligible for Medicare or similar coverage under state or federal governmental plans.

Chapter 264 (House Bill 1266)

This bill amends § 38.2-3407.4:1 in the Accident and Sickness Insurance Chapter that requires the adoption by the Commission of a uniform referral form. The amended bill requires the Commission to adopt a uniform referral form for managed care health insurance plans (MCHIPs). The Commission is to incorporate only the data elements adopted by the Health Care Financing Administration (HCFA) for Electronic Data Interchange standards. The MCHIPs must use the uniform referral form as the only instrument for referrals.

Chapter 460/496 (Senate Bill 221/House Bill 914)

These bills create a new § 38.2-3411.3 in the Mandated Benefits Article of the Accident and Sickness Insurance Chapter. The bills apply to insurers issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group subscription contracts; and each health maintenance organization providing a health care plan for health care services. The policies, plans, and contracts must provide coverage for all routine and necessary immunizations for newborn children. Benefits shall apply to immunizations administered to each newborn child from birth to 36 months of age. The new section defines “routine and necessary

immunizations" as immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations as may be prescribed by the Commissioner of Health.

The new requirements do not apply to any policy, contract or plan under which the policyholder has elected to obtain coverage for child health supervision services offered and made available under § 38.2-3411.1 or to short-term travel, accident only, limited or specified disease policies, Medicare supplement policies, or short-term nonrenewable policies of not more than six months' duration.

Chapter 465 (Senate Bill 541)

The bill adds § 38.2-3418.12 to the Accident and Sickness Insurance Chapter and amends § 38.2-4319 in the Health Maintenance Organizations Chapter. The bill applies to insurers issuing individual and group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, corporations providing individual or group subscription contracts and health maintenance organizations providing a health care plan for health care services. The policies, plans and contracts must offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. The bill applies to policies, contracts, and plans delivered, issued for delivery or renewed on and after July 1, 2000.

The reimbursement for treatment of morbid obesity is to be determined according to the same formula by which charges are developed for other medical and surgical procedures. The coverage is to have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Insurers are not to restrict access to surgery for morbid obesity based upon dietary or other criteria not approved by the National Institutes of Health.

The bill defines "morbid obesity" as (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, (iii) a BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared as used in the bill.

The provisions of the bill do not apply to short-term travel, accident only, limited or specified disease policies or contracts designed for persons eligible for Medicare or similar state or governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

Chapter 479 (House Bill 1176)

This bill amends § 2.1-20.1 (Administration of the Government Generally Title) relating to state employee health coverage and § 32.1-325 (Health Title) pertaining to the requirements for coverage provided by the medical assistance services plan. The bill also adds § 38.2-3407.4:2 to the Accident and Sickness Insurance Provisions Chapter.

Section 38.2-3407.4:2 applies to each insurer proposing to issue individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing subscription contracts; and health maintenance organizations (HMOs) providing health care plans that include coverage for prescription drugs, whether on an inpatient or outpatient basis or both. The policies, contracts, and plans must provide for the issue of a standardized prescription benefits identification card or other technology that complies with the National Council for Prescription Drug Programs (NCPDP) standards set forth in the NCPDP Pharmacy Card Implementation Guide (Guide).

The standardized prescription benefits identification card or other technology must be capable of accommodating the mandatory data elements included in the Guide and must be issued to each new insured, subscriber, or enrollee and reissued when there are coverage changes that affect the data elements on the card or other technology. New or reissued cards must comply with the most recently issued Guide.

A standardized prescription benefits card is not considered to be part of the evidence of coverage and is not required to be filed with or approved by the Commission.

The bill does not apply to short-term travel, or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

The bill applies to contracts, policies, or plans delivered, issued for delivery, or renewed in Virginia on and after July 1, 2002.

The state employee coverage and coverage under the medical assistance services plan must also require the standardized prescription benefits identification card, or other technology that complies with the NCPDP standards.

A second enactment clause provides that the bill is not effective unless it is reenacted by the 2001 Session.

Chapter 508 (Senate Bill 284)

This bill adds § 38.2-3407.9:02 to the Accident and Sickness Provisions Chapter. The bill provides that insurers proposing to issue individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing subscription contracts; or health maintenance organizations providing health care plans may not exclude coverage for any prescription drug solely on the basis of the time elapsed since FDA approval of the drug. The bill applies if the policy, contract, or plan includes coverage for prescription drugs.

Chapter 532 (House Bill 923)

This bill adds § 38.2-5202.1 to the Long-term Care Insurance (LTC) Chapter and revises § 38.2-4123 to make the LTC Chapter applicable to fraternal benefit societies. Sections 38.2-4214 and 38.2-4319 are revised to clarify that the LTC chapter applies to health services plans and health maintenance organizations. The bill requires **individual** LTC policies or certificates to refund premiums in the event of cancellation or termination of coverage. The refund must be made by the insurer within 30 days of the effective date of the termination. The refund must be computed on a pro rata basis whether it is terminated by the insurer or the insured.

The bill applies to individual LTC policies, contracts, and plans delivered, issued for delivery, reissued, renewed or extended or at any time when any term is changed or any premium adjustment is made. The bill does not apply to group LTC insurance or individual LTC policies, contracts or plans providing coverage for the duration of the insured's life if the premium is paid in a single installment.

Chapter 540 (House Bill 1236) – EFFECTIVE JANUARY 1, 2001

This bill amends §§ 38.2-3503 and 38.2-3504 (the uniform and other provisions, respectively) in the Individual Health Insurance Coverage Article of the Accident and Sickness Insurance Chapter, § 38.2-4214 in the Health Services Plans Chapter and § 38.2-4319 in the HMOs Chapter to require a company to compute earned premiums on a pro rata basis when a policy is canceled at the insured's request, as addressed in § 38.2-3503, or by the company, as addressed in § 38.2-3504. The company must promptly return the unearned premium upon receipt of a written notice of cancellation from the insured, or notice of cancellation delivered to the insured by the company as applicable. The cancellation is not to prejudice any claim prior to the cancellation.

The bill applies to individual accident and sickness policies, health services plans contracts, and HMO health care plans issued, renewed, or extended on or after July 1, 2000.

Chapter 544 (Senate Bill 455)

This bill amends § 38.2-3432.2 in the Group Market Reforms and Individual Coverage Offered to Employees of Small Employers Article of the Accident and Sickness Insurance Chapter. The bill exempts health insurance coverage or products available only through a bona fide association or associations from subdivision A 2 of § 38.2-3432.2, the subdivision that requires that coverage offered in the small group market must be made available to all small employers.

Chapter 559 (House Bill 1511) – EFFECTIVE JANUARY 1, 2001

This bill amends §§ 38.2-5200, 38.2-5202, 38.2-5203, and 38.2-5207 and adds §§ 38.2-5209 and 38.2-5210 to the Long-term Care (LTC) Insurance Chapter to add a definition of "qualified long-term care insurance policy" or "federally tax-qualified long-term care insurance contract." The bill adds language that states the Commission shall promulgate regulations for LTC policies and certificates that it deems appropriate.

Section 38.2-5203 is amended to add the following to the list of prohibited provisions for LTC policies: (i) policies being issued on medical or health status by an agent or third-party administrator and (ii) policies providing that an insurer which has paid benefits under a LTC policy or certificate can recover benefit payments if the policy or certificate is rescinded.

The bill also provides that no LTC policy or certificate may be marketed as a qualified LTC policy or federally tax-qualified LTC contract unless the policy prominently discloses such in a statement.

The bill includes provisions on incontestability that allow rescission by the insurer or denial of a claim for a policy in force less than six months, if there was material misrepresentation in acceptance of coverage. If a policy has been in force between six months and two years, an insurer may rescind or deny a claim after showing material misrepresentation in the acceptance of coverage that pertains to the condition for which benefits are sought. After a policy has been in force two years, the policy is not contestable based on misrepresentation alone; the insured must have knowingly and willfully misrepresented relevant facts relating to his or her health. The bill does not apply if the insured dies and there is a remaining death benefit of accelerated benefits for a life policy. The provisions of §§ 38.2-3305 or 38.2-3326 would apply to remaining

death benefits. The bill applies to life policies that have accelerated benefits in other situations.

The bill requires the offer of a non-forfeiture benefit that may be in the form of a rider. If the policyholder or certificate holder does not select the benefit, the insurer must provide a contingent benefit if there is a lapse. The benefit must be available for a specified period of time after a substantial premium increase.

A second enactment clause requires the Joint Commission on Health Care (JCHC) and the Bureau to study the work of the NAIC on reporting requirements and disclosures of information for LTC policies. The JCHC and the Bureau must report to the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor before the 2001 Session.

The bill applies to LTC policies or certificates delivered, issued for delivery, or renewed in Virginia on or after July 1, 2000. The requirements of § 38.2-5210 take effect 60 days after (i) promulgation of regulations by the SCC providing for the non-forfeiture benefits or (ii) January 1, 2001, whichever is earliest.

Chapter 630 (House Bill 660)

This bill amends § 38.2-3407.9 in the Accident and Sickness Insurance Chapter that relates to the assignment of benefits for ambulance services.

The bill prohibits insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, corporations providing subscription contracts; or HMOs providing health care plans from establishing or promoting an emergency medical response and transportation system that encourages or directs access with or in substitution of an emergency 911 system or other state, county or municipal emergency medical system for ambulance services. The bill provides that entities subject to the bill may use transportation other than 911 systems and state, county or municipal emergency medical systems for services that are not ambulance services.

The bill also prohibits policies, plans and contracts from requiring a person to obtain prior authorization before accessing an emergency 911 system or another state, county or municipal emergency medical system for emergency services.

Chapter 725 (Senate Bill 358)

This bill amends § 38.2-3412.1:01 in the Accident and Sickness Insurance Chapter that requires coverage for biologically-based mental illness. The bill clarifies the effective date for policies that were in effect when the original language for the section became

effective on January 1, 2000. The section applies to insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2000, or when a term in the policy, contract, or plan is changed or a premium adjustment is made on or after January 1, 2000.

The bill also deletes the word "individual" in subsection A to clarify that the law does not apply to individual accident and sickness insurance policies, individual subscription contracts or individual health care plans provided by HMOs.

NOTE: Although not related directly to the amendments provided in the above bill, the Bureau recently concluded an analysis of § 38.2-3412.1:01 concerning the inclusion of drug addiction among the conditions considered to be *biologically based mental illnesses*, and whether smoking cessation therapies and services were permitted to be excluded from coverage requirements. The determination has been made that exclusions for smoking cessation therapies will not be disapproved, and that prior objections to earlier form submissions will be withdrawn. Carriers may contact the Bureau's Life and Health Forms & Rates Section for further clarification.

Chapter 873 (House Bill 1111)

This bill amends § 38.2-3407.9:01 in the Accident and Sickness Chapter relating to prescription drug formularies. The bill requires insurers to allow enrollees a prescription drug not in the formulary if the insured was taking the drug for at least six months before the formulary was developed or revised. There is to be no additional cost sharing. The prescribing physician must determine that the formulary drug is inappropriate for the patient or may present a significant health risk to the patient. The substitution of a generic equivalent drug, approved by the FDA in place of a branded version of the drug, does not constitute a change in drug therapy.

The insurer, corporation, or health maintenance organization must act on requests within one business day after reasonable investigation and consultation with the physician.

Chapter 888 (Senate Bill 26)

This bill adds §38.2-3418.7:1 to the Accident and Sickness Insurance Chapter. The bill applies to individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing individual or group accident and sickness subscription contracts; and health maintenance organizations providing health care plans. The policies, contracts, and plans must provide coverage for colorectal screening on and after July 1, 2000, if they are delivered, issued for delivery, or renewed in Virginia.

The coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy, or colonoscopy, or in appropriate circumstances, radiologic imaging, must be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies in the recommendations.

The coverage is not to be more restrictive than or separate from coverage for any other illness, condition, or disorder for the purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits or episodes, or treatment limits, copayment and coinsurance factors, and benefit year maximums for deductibles, copayments, and coinsurance factors.

The bill does not apply to (i) short-term travel, accident only, limited or specified disease policies, except cancer policies, (ii) short-term nonrenewable policies of not more than six months duration or (iii) policies or contracts designed for issuance to persons eligible for Medicare, or other similar coverage under state or federal governmental plans.

Chapter 922 (House Bill 726)

House Bill 726 was introduced in order to clarify provisions of 1999 House Bill 871/Senate Bill 1235, the omnibus health insurance bills. The bill amends §§ 32.1-137.6, 32.1-137.15 (Health Title), 38.2-3407.10, 38.2-3407.11:1, 38.2-3418.9 (Accident and Sickness Insurance Chapter), 38.2-4214 (Health Services Plans Chapter), 38.2-4319 (HMO Chapter), 38.2-4509 (Dental or Optometric Services Plans), 38.2-5803, 38.2-5804 (Managed Care Health Insurance Plans Chapter), and 38.2-5900 through 38.2-5904 (Adverse Utilization Review Decisions Chapter).

The amendments to §§ 32.1-137.6 and 32.1-137.15 and 38.2-5804 clarify that the Managed Care Ombudsman is an office, not a person. The amendment to subsection L of § 38.2-3407.10 clarifies confusing language regarding the preauthorization of medical treatment. The amendment to subsection M of § 38.2-3407.10 clarifies that the written notice that carriers must provide to their group policyholders before any benefit reductions are made must be a separate and distinct notification, and cannot be combined with other notifications or marketing materials.

The amendment to subsection A of § 38.2-3407.11:1 replaces the term “direct access” with the term “standing referral.” Since the primary care physician (PCP) makes the initial referral of the patient to the specialist, this section refers in this context to a standing referral, not to direct access.

The amendments to subsections B and C of § 38.2-3407.11:1 combine old subsections B and C into a new subsection B. The new subsection B clarifies that the PCP makes the initial referral of a patient to a specialist and authorizes a treatment period. During that period, the patient is permitted to go directly to the specialist for treatment of the special condition without further referrals from the PCP. The new subsection C of § 38.2-3407.11:1 (formerly subsection D) also clarifies that the "specialist" for the treatment of the special condition is a "participating specialist."

The amendment to subsection B of § 38.2-3418.9 removes the unnecessary reference to Milliman & Robertson's nationally recognized guidelines in outlining the standards for length of hospital stays for the two types of vaginal hysterectomies.

The amendments to §§ 38.2-4214, 38.2-4319 and 38.2-4509 sweep in § 38.2-5903, the assessment provision of Chapter 59 of Title 38.2, so that health services plans, HMOs and dental/optometric plans are subject to the assessment to fund the regulatory costs of administering Chapter 59 of Title 38.2. These three sections were also amended to correct non-substantive drafting errors from the 1999 legislation.

Section 38.2-5803 is amended to add a new subdivision 5 of subsection A to require that each evidence of coverage issued by a managed care health insurance plan (MCHIP) include information on how to contact the Office of the Managed Care Ombudsman, including the mailing address, e-mail address and telephone number.

NOTE: Any amendments or form revisions necessary to achieve compliance with this requirement must be filed for approval with the Bureau of Insurance in accordance with §§ 38.2-316 and/or 38.2-4306.

The amendments to § 38.2-5900 add a number of definitions to clarify the scope of Chapter 59:

"Covered person" is defined as an individual who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to an MCHIP as defined in and subject to regulation under Chapter 58 of Title 38.2, when such coverage is provided under a contract issued in this Commonwealth.

"Final adverse decision" is defined to mean a utilization review determination denying benefits or coverage concerning which all internal appeals available to the covered person pursuant to Title 32.1 have been exhausted.

"Treating health care provider" means a licensed health care provider who renders or proposes to render health care services to a covered person.

"Utilization review," which is not otherwise defined in Title 38.2, is defined as a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other

health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, MCHIP licensee or other entity or person. Utilization review includes, but is not limited to, preadmission, concurrent and retrospective medical necessity determination and review related to the appropriateness of the site at which services were or are to be delivered. Utilization review shall also include determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures by whatever terms designated in the evidence of coverage. Utilization review does not include (i) any denial of benefits or services for a procedure which is explicitly excluded pursuant to the terms of the contract or evidence of coverage, (ii) any review of issues concerning contractual restrictions on facilities to be used for the provision of services, or (iii) any determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance in any of the classes of insurance defined in Chapter 1 of Title 38.2.

"Utilization review entity" is defined as an insurer or MCHIP licensee that performs utilization review or upon whose behalf utilization review is performed with regard to the health care or proposed health care that is the subject of the final adverse decision.

Subsection A of § 38.2-5901 is amended so that the original language of the subsection providing for an appeal by a covered person or his/her treating health care provider to the Bureau of Insurance for review of any final adverse decision in accordance with § 38.2-5901 is stricken, and the appeal is now subject to regulations promulgated by the State Corporation Commission. Subsection A is also amended to clarify that it is the Bureau of Insurance, not the Commission, that will collect, waive or charge the $50 nonrefundable filing fee for an appeal.

Subsection D of § 38.2-5902 provides that all such fees collected by the Bureau will be credited to the fund for the maintenance of the Bureau as provided in subsection B of § 38.2-400.

The language in subsections A and B of § 38.2-5901 limiting appeals to those involving a service or benefit costing more than $500 is amended to cover a health service for which the actual cost to the covered person exceeds $300 if the final adverse decision is not reversed.

Subsections B and C of § 38.2-5901 and subsection A of § 38.2-5902 are amended to expand the time limits so that the Bureau of Insurance, the parties to the appeal and the external reviewer have sufficient time to fulfill their respective responsibilities under Chapter 59 of Title 38.2. The Bureau now has ten working days, not five, in which to complete the preliminary review of an appeal and five working days, not three, to notify the applicant and the utilization review entity in writing as to whether or not the appeal has been accepted for review. The covered person and utilization review entity now

have 20 working days, not ten, to provide all copies of the necessary medical records to the Bureau. Failure to comply with the request for medical records within 20 days from the date of the request for records may result in dismissal of the appeal or reversal of the final adverse decision, at the discretion of the Commissioner of Insurance. The Bureau now has an additional 20 working days, not 10, to request additional medical records from any party. Subsection D of § 38.2-5901 is amended to clarify that it is the Bureau, not the Commission, which may provide an extension of time to any of the parties upon good cause shown. The utilization review entity now has 30 days from the date that all documentation has been received, not 30 days from the date the Bureau accepted the appeal, to complete its work.

Subsection A of § 38.2-5902 is also amended to clarify the language regarding the written ruling of the Commissioner of Insurance with regard to the appeal to impose a ten-day time limit on the Commissioner for the issuance of the written ruling. The language also clarifies that the Commissioner's written ruling affirms the recommendation of the impartial health entity unless the Commissioner has reason to conclude that the impartial health entity acted arbitrarily or capriciously. Subsection A of § 38.2-5902 is also amended to insert the term "utilization review entity" in place of "issuer of the covered person's policy or contract" for clarity and consistency.

Sanctions have also been added at subsection C of § 38.2-5901 and subsection A of § 38.2-5902. Subsection C of § 38.2-5901 provides the Commissioner of Insurance the authority to dismiss an appeal or reverse a final adverse decision in situations in which parties to an appeal fail to provide required information in a timely manner. Subsection A of § 38.2-5902 provides that if the utilization review entity fails to comply with the Commissioner's written ruling within 30 days of the ruling, it is a knowing and willful violation of the section, invoking the provisions of § 38.2-218.

Subsection B of § 38.2-5902 provides the Bureau the authority to determine which medical peer review organizations and independent utilization review companies have the necessary credentials to qualify to perform such reviews. This amendment reinserts language stricken from the 1999 omnibus health insurance bills.

Provisions of § 38.2-5904 are amended to clarify some of the responsibilities of the Office of the Managed Care Ombudsman (Office) and the fact that the Commission, of which the Office is one part, will respond to requests from the Virginia General Assembly or the Joint Commission on Health Care for information or reports.

Chapter 1060/1025 (House Bill 1376/Senate Bill 274)

This bill amends and clarifies § 38.2-3418.10, the mandate for diabetes coverage, contained in the Mandated Benefits Article of the Accident and Sickness Insurance Chapter. The bill clarifies that coverage for outpatient self-management training and education must be provided "in person." The bill further clarifies that the terms,

"equipment" and "supplies," as used in § 38.2-3418.10, are not to be considered durable medical equipment.

The bill provides that a managed care health insurance plan, defined in § 38.2-5800 et seq., is permitted to require that health care professionals described in the mandate be members of the managed care health insurance plan's provider network. The network must include sufficient health care professionals to provide the benefits.

Finally, the bill prohibits insurers, corporations, and health maintenance organizations from imposing policy year or calendar year dollar or durational benefit limits or maximums for coverage under the section.

FINANCIAL REGULATION BILLS

Chapter 46 (Senate Bill 52) – EFFECTIVE JANUARY 1, 2001

This bill relates to accounting practices and procedures applicable to insurers. It amends § 38.2-213 (Provisions of a General Nature Chapter); §§ 38.2-1306.2, 38.2-1312, 38.2-1315, 38.2-1329 (Reports, Reserves and Examinations Insurance Holding Companies Chapter); 38.2-4123 (Fraternal Benefit Societies Chapter); 38.2-4319 (HMOs Chapter); 38.2-4604 (Title Insurance Chapter); adds § 38.2-1306.3 in the Valuation and Admissibility of Assets Article of Chapter 13; and repeals §§ 38.2-1307, 38.2-1308, 38.2-1309 and 38.2-1310.1. This bill incorporates by reference various guidances set forth in the accounting practices and procedures manuals of the National Association of Insurance Commissioners (NAIC). The NAIC recently adopted Statements of Statutory Accounting Practices (SSAPs) that will be the basis of new accounting guidance that will become effective for statements and disclosures filed on and after January 1, 2001, which is the effective date of this legislation. Existing provisions regarding the valuation of bonds (§ 38.2-1307), securities (§ 38.2-1308), and real estate, leaseholds and mortgages (§ 38.2-1310) are repealed. References to the guidance set forth in the NAIC accounting practices and procedures manuals are substituted for current provisions that identify assets which are not admitted for purposes of determining an insurer's financial condition.

Chapter 47 (Senate Bill 54 – Bureau Bill)

This bill amends § 38.2-4214 (Health Services Plans Chapter); § 38.2- 4319 (HMOs Chapter); § 38.2-4509 Dental or Optometric Services Plans Chapter); §§ 38.2-5500 - 38.2-5510 (Risk-Based Capital Act for Insurers Chapter); and adds § 38.2-5515 to apply the Risk-Based Capital (RBC) Act to "health organizations," including health maintenance organizations, health services plans, and dental or optometric services plans as well as some insurers. From July 1, 2000, until January 1, 2001, the monitoring provisions of the RBC Act will apply to HMOs. Effective January 1, 2001,

these health organizations operating in Virginia will be subject fully to the RBC Act. The risk-based capital of health organizations will be determined in accordance with the formula set forth in instructions adopted by the NAIC. The Commission may exempt from the RBC Act a domestic health organization that writes direct business only in Virginia and assumes no reinsurance in excess of five percent of direct premium written, and writes direct annual premiums of $2 million or less for comprehensive medical coverages or is a dental or optometric services plan that covers fewer than 2,000 lives.

Chapter 51 (Senate Bill 206 – Bureau Bill)

This bill amends § 38.2-216 to require a domestic insurer to obtain written approval from the Commission prior to entering into or modifying any reinsurance treaty or risk-sharing arrangement if in any 12-month period the reinsurance premium or the anticipated change in the insurer's liabilities exceeds 50 percent of the insurer's surplus to the policyholders as of the preceding December 31. Failure to obtain such approval is punishable as a Class 1 misdemeanor.

Chapter 52 (Senate Bill 207)

This bill amends §§ 13.1-752, 13.1-914, 13.1-930, 13.1-1064 (Corporations Title) and § 50-73.69 in the Partnerships Title to provide for the automatic termination of corporate existence, revocation of certificate of authority to transact business, or cancellation of certificate of limited liability company or limited partnership if an entity's registered agent has resigned and the entity does not timely appoint a new registered agent. The bill requires the Commission to mail a notice to the entity by first class mail and provides a minimum of two months for the entity to make the new appointment. Currently, the failure to appoint a new registered agent in a timely manner results in termination or revocation after the entity is cited in a rule to show cause, which is followed by the opportunity for a hearing before the Commission. The measure applies only to entities whose registered agents file a certificate of resignation on or after January 1, 2001.

Chapter 155 (House Bill 44)

The bill amends §§ 38.2-1425 and 38.2-1426 in the Investments Chapter relating to investments by domestic insurers in a bank or trust company. The bill eliminates the earnings test that allows domestic insurers to invest in the capital stock of only those banks or trust companies that earned a minimum rate of return. As a result of the amendments, an insurer’s investments in the common stock of banks will remain subject to § 38.2-1425 while investments in bank debt issues, including notes, debentures, and most preferred stock, will become subject to provisions §§ 38.2-1421, 38.2-1423 and elsewhere pertaining to investments generally in corporate obligations and debt securities issued by other business entities.

Chapter 169 (House Bill 756)

The bill amends § 38.2-1019 in the Organization, Admission and Licensing of Insurers Chapter to require that any insurer domiciled in another state that becomes a domestic

insurer shall be recognized as an insurer initially licensed, in another jurisdiction, as of the date it was first licensed as an insurer in the state of its original domicile.

Chapter 171/204 (House Bill 835/Senate Bill 593)

This bill amends § 38.2-4504 in the Dental or Optometric Services Plans Chapter to eliminate the requirement that a nonstock corporation administering a dental or optometric plan be an agent for the participating dentists and optometrists. A change in a nonstock corporation's agent status must be approved by the Commission after review of the corporation's financial condition and method of doing business. Nonstock corporations not acting as agents for dentists and optometrists must keep a contingency reserve of no less than the amount required for 45 days of operating expenses.

Chapter 206 (Senate Bill 759)

The bill amends § 38.2-1700 (Virginia, Life, Accident and Sickness Insurance Guaranty Associations Chapter) to provide that the Life, Accident and Sickness Insurance Guaranty Association will provide coverage for structured settlement annuities based on the residence of the injured person receiving payments under the annuity.

Chapter 266 (House Bill 1392)

The bill amends § 55-531 (Property and Conveyances Title) to expand the categories of nonprofit health care entities that are required to notify the Attorney General of a proposed disposition of assets, in order that the Attorney General may exercise authority over their activities. The categories of nonprofit health care entities that are included by this legislation include (i) licensed nursing homes, (ii) certified nursing facilities, and (iii) registered continuing care facilities.

Chapter 503 (Senate Bill 73 – Bureau Bill)

The bill amends §§ 38.2-4300, 38.2-4301, 38.2-4302, 38.2-4307.1, 38.2-4310, 38.2-4317.1 and 38.2-4319 in the HMOs Chapter by adding definitions at §§ 38.2-4300 for “acceptable securities,” “excess insurance,” and “net worth;” describing more fully the content of filings required by §§ 38.2-4301, 38.2-4302 and 38.2-4307.1; and adding new statutory cross-references in §§ 38.2-4317.1 and 38.2-4319. Amendments at § 38.2-4310 and a new § 38.2-4310.1 provide for an initial deposit prior to licensure of an amount not less than $300,000 and clarify the policies and procedures for using deposited amounts.

MISCELLANEOUS BILLS

Chapter 50 (Senate Bill 79)

This bill amends the "sweep-in" provisions in the chapters of Title 38.2 addressing health services plans (§ 38.2-4214), health maintenance organizations (§ 38.2-4319), legal services plans (§ 38.2-4408), and dental and optometric plans to include a cross-reference to § 38.2-209 (Provisions of a General Nature Chapter), which pertains to payment of the reasonable attorney's fees of insured individuals in civil suits to determine the extent of coverage, if a court determines that such an entity did not act in good faith in denying coverage or failing or refusing to make payment under a policy.

Chapter 101 (Senate Bill 372)

The bill adds in Title 59.1 (Trade and Commerce) the Uniform Computer Information Transactions Act (UCITA). The UCITA was promulgated by the National Conference of Commissioners on Uniform State Laws. Modeled after the Uniform Commercial Code, Article 2, the UCITA is designed to govern transactions of computer information.

Chapter 527 (House Bill 762)

This bill adds § 38.2-221.1 (Provisions of a General Nature Chapter) to allow insurers to request that certain information furnished to the Commission be considered confidential proprietary information. This section applies only to information the Commission requests during the course of a market conduct examination pursuant to Article 4 of Chapter 13 or inspection request or inquiry pursuant to §§ 38.2-200. Such confidential proprietary information shall not be subject to subpoena or public inspection. The bill makes it clear that the Commission is not prohibited from using the confidential proprietary information in the furtherance of any regulatory or legal action or from publishing its market conduct reports, opinions, orders, decisions, findings, judgments, or any other report containing aggregated findings as long as the confidential proprietary information is not disclosed unless the Commission has found, after providing the insurer notice and opportunity to be heard, that such information is not confidential proprietary information.

Chapter 669 (House Bill 494) – EFFECTIVE APRIL 8, 2000

The bill adds § 38.2-226.3 (Provisions of a General Nature Chapter) to exclude from insurance regulation the operation of a health care services plan that was sponsored by a private non-profit agency organized in 1965 and designated as a community action agency pursuant to Chapter 39 of Title 2.1. **The measure expires July 1, 2001.**

Chapter 753 (House Bill 1211)

This bill amends § 38.2-4301 in the Health Maintenance Organization (HMOs) Chapter to exempt an HMO licensed in a state contiguous to Virginia from the requirement that it be licensed in Virginia if the HMO contracts on a limited basis with health care providers in Virginia for the provision of services to enrollees under a group contract not delivered or issued for delivery in Virginia, and (i) the number of Virginia residents receiving such services does not exceed 500 enrollees of the HMO and (ii) the contracts with the providers include a hold harmless clause.

Chapter 862/934 (House Bill 1366/Senate Bill 718)

This bill amends § 38.2-3407.10 in the Accident and Sickness Insurance Provisions Chapter and amends § 38.2-4319 in the HMOs Chapter. The bill applies to insurers proposing to issue individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing subscription contracts; and HMO's providing health care plans.

The bill adds Subsection O, requiring that if a provider panel contract between a carrier, or other entity providing hospital, physician or other health care services to a carrier includes provisions requiring a provider, as a condition of participating in one of the carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that carrier or other entity, then the contract shall contain a provision permitting the provider to refuse participation in one or more such other provider panels at the time the contract is executed without affecting the provider's status as a member of or for eligibility in other existing or new provider panels.

The bill does not apply to the Medallion II and children's health insurance plan administered by or pursuant to contract with the Department of Medical Assistance.

The bill requires that the new language shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 2000.

Chapter 995 (House Bill 499)

This bill adds in Title 59.1 (Trade and Commerce) the Uniform Electronic Transaction Act (UETA). The UETA was promulgated by the National Conference of Commissioners on Uniform State Laws; a resolution supporting UETA has been adopted by the NAIC. UETA provides that records and decisions of insurers and others will not be invalidated solely because of their electronic format. The bill amends multiple sections of the Code of Virginia pertaining to electronic signatures by adding reference to the new UETA in Title 59.1.