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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

May 10, 2001

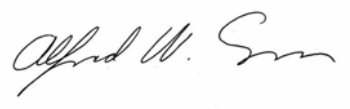
Administrative Letter 2001-3

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

RE: **Legislation Enacted by the 2001 Virginia General Assembly**

We have attached for your reference staff summaries of certain statutes enacted or amended and re-enacted during the 2001 Session of the Virginia General Assembly. **The effective date of these statutes is July 1, 2001, 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 2001 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 2001-XXX

TABLE OF CONTENTS

FINANCIAL REGULATION BILLS

PRIVACY AND CONFIDENTIALITY BILLS

INSURANCE AGENTS AND CONTINUING EDUCATION BILLS

LIFE AND HEALTH BILLS

PROPERTY AND CASUALTY BILLS

NOTE:
UNLESS OTHERWISE INDICATED, ALL BILLS ARE EFFECTIVE JULY 1, 2001

FINANCIAL REGULATION BILLS

Chapter 239 (House Bill 1892)

HB 1892 amends the "provider panel" provisions at § 38.2-3407.1 (Accident and Sickness Insurance Chapter) to clarify rights and expectations of physicians and other providers who enter provider panel contracts with carriers directly or indirectly through another provider. Under the amendment, if a carrier or a provider who is a member of the panel, contracts with an unaffiliated carrier with reimbursement rates or with managed care procedures that differ materially from those in the original contract, the provider must be allowed to refuse participation with such unaffiliated carrier. Further, the status of the physician or other provider as a member of, or as being eligible for, such other existing or new provider panel shall not be adversely affected by the refusal to participate. Specific language clarifies that conducting economic profiling or requiring a patient to obtain primary care physician referral to a specialist would be considered a material difference; however, utilization review pursuant to Article 1.2 of Chapter 5 of Title 32.1 (Health) shall not constitute a materially different managed care procedure. Other specific language states the provisions of subsection O shall apply to provider panels utilized by health maintenance organizations (HMOs) and Preferred Physician Organizations (PPOs). Amendments in subsection Q make the provisions of subsection O applicable for contacts entered into, reissued, extended or renewed on or after July 1, 2001.

Chapter 387 (House Bill 2721)

HB 2721 amends § 38.2-1428 (Investments Chapter) relating to hedging transactions. The amendments add reference to § 38.2-1443 (foreign securities) thereby authorizing domestic insurers also to effect or maintain bona fide hedging transactions pertaining to foreign securities. Currently, hedging transactions may pertain to other categories of domestic and Canadian obligations. This bill also expands the definition of a bona fide hedging transaction to include the purchase or sale of a contract, warrant, option, call, put or right for the purpose of (i) minimizing foreign currency risks or (ii) offsetting currency risks and other items that qualify for hedge accounting.

Chapter 545 (House Bill 2162)

EFFECTIVE JULY 1, 2002

HB 2162 amends multiple provisions, including portions of Chapter 9 of Title 13.1 (Virginia Stock Corporation Act) concerning stock corporations, to adopt provisions from the Revised Model Business Corporations Act. These amendments streamline procedures for (i) domestication of foreign corporations in Virginia and Virginia corporations in foreign jurisdictions and (ii) for converting domestic limited liability companies to domestic corporations and domestic corporations to domestic limited liability companies. The new provisions and fees are effective July 1, 2002.

Chapter 707 (Senate Bill 987)

SB 987 places a definition of "insurance" in Title 38.2 for the first time. The amendment, at § 38.2-100 (General Provisions Chapter), defines insurance, for purposes of Title 38.2, as the business of transferring risk by contract wherein a person, for a consideration, undertakes to indemnify another person, to pay or provide a specified or ascertainable amount of money, or to provide a benefit or service upon the occurrence of a determinable risk contingency. As defined, "insurance" specifically includes the issuance of group and individual contracts, certificates, or evidences of coverage by health services plans, HMOs, legal services organizations or legal services plans, and dental or optometric services plans. The definition clearly recognizes HMOs as persons who transact an insurance business. Nevertheless, the addition of a definition of “insurance” will have no significant impact on the manner in which licensed HMOs are regulated.

Chapter 726 (House Bill 2255)

SB 2255 represents Virginia's response to § 311 of GLBA (the Gramm-Leach-Bliley Financial Services Modernization Act, Public Law 106-102), which authorizes mutual insurers to redomesticate from a state that has no mutual holding company (MHC) statute to a state which specifically recognizes compliant mutual holding company reorganizations. In order to assure that Virginia’s mutual insurers are not placed in the position of having to make such a decision, HB 2255 amends provisions in Chapter 10 of Title 38.2 concerning demutualizations and mutual holding companies. A new article in Chapter 10 (Organizations, Admission and Licensing of Insurers) recognizes the formation of a MHC and authorizes conversion of a mutual insurer to a stock insurer. These provisions specify that all eligible members of the mutual insurer are to become members of the MHC; that the MHC shall at all times own not less than a majority of the issued shares of the voting stock of the converted company; that MHC member interests are not transferable; and that member interest shall not constitute a security under the laws of Virginia.

Plans for conversion must be fair and equitable with regard to the interests of the members of the mutual company, and require the approval of the Commission and the

approval of two-thirds of the votes cast by eligible members at a meeting in person or by proxy. Related amendments at § 38.2-1005 clarify that an insurance society or nonstock company licensed under any chapter other than Chapter 10 must become a Chapter 10 mutual insurer prior to seeking approval for conversion to a stock insurance company.

PRIVACY AND CONFIDENTIALITY BILLS

Chapter 371 (House Bill 2157)

HB 2157 was adopted in recognition of the federal requirements imposed under GLBA (the Gramm-Leach-Bliley Financial Services Modernization Act, Public Law 106-102).

Depository Institutions Selling or Soliciting Insurance

Section 38.2-513 and subsection B of § 38.2-514 of the Code of Virginia have been replaced with a new section numbered § 38.2-513.1 in the Unfair Trade Practices Act (Title 38.2, Chapter 5). The new section sets forth the obligations of depository institutions that are selling or soliciting insurance. Depository institutions must:

1. be licensed as agents in accordance with Chapter 18 (Insurance Agents) of Title 38.2;
2. inform their customers that the customer's choice of an insurance company will not affect the credit decision or credit terms in any way;
3. maintain separate books and records relating to their insurance transactions for three years;
4. keep their insurance sales activities (to the extent practicable) physically segregated from areas where retail deposits are routinely accepted;
5. keep the insurance transaction separate from the credit transaction (except for credit insurance and flood insurance); and
6. give their customers a notice stating that the insurance policy is not a deposit, is not FDIC insured, is not guaranteed by the depository institution, and involves investment risk, where appropriate.

Depository institutions **may not**:

1. reject an insurance policy just because it is issued by a person not associated with the depository institution or its affiliate;
2. pay or receive commissions except in accordance with Chapter 18 (an exception is made for payment of compensation for the referral of a customer, with certain stipulations set forth in the Code);
3. make loans conditional on the purchase of insurance from the depository institution or its affiliate;

4. require a separate charge for the handling of insurance unless the charge would be required if the depository institution or its affiliate were the agent;
5. use advertisements that would lead a person to believe that the federal or state government is guaranteeing the insurance products sold by the depository institution or its affiliate;
6. include the expense of premiums (except for credit, flood, and title insurance premiums) in the credit transaction without the customer's written consent; or
7. release insurance or health information about a customer without the customer's written consent except as permitted in the law.

With certain exceptions, these provisions also apply to *any* person who lends money or extends credit and who sells or solicits insurance.

Privacy Protection

Chapter 6 of Title 38.2 (Insurance Information and Privacy Protection Act) currently requires an information practices notice to be given when the policy is issued or delivered or at the time information is collected from a source other than from the applicant or from public records. This notice is also required to be given at least every two years if information is collected from a source other than from the policyholder or from public records. This will remain in the law, but the bill now contains an additional provision requiring an information practices notice to be given *every year* describing the types of *financial* information that may be disclosed to affiliates and nonaffiliated third parties. Financial information is personal information that is not medical record information or health care payment records. Insurers and agents will either be able to send a combined information practices notice or two separate notices.

If financial information is disclosed about an applicant to a nonaffiliated third party before the policy is issued, an information practices notice must be given to the applicant prior to the time the information is disclosed. However, this notice does not have to be given to the applicant if financial information is disclosed as permitted under one of the exceptions in § 38.2-613. For example, if financial information is given to a nonaffiliated third party to enable that party to perform an insurance function for the insurer, an information practices notice does not have to be given prior to the issuance of a policy. An example of this would be an insurer giving a social security number to a vendor to collect motor vehicle records (MVR) or giving a name and address to a vendor to conduct a property inspection. But if financial information is disclosed to a nonaffiliated third party for marketing purposes, an information practices notice must be given before the information is disclosed. This does not negate the requirement under § 38.2-604 that insurers or agents must give an information practices notice to an applicant if information is *collected* about that applicant from an outside source such as an MVR or a credit report.

The information practices notice given for financial information must also inform the insured of his right to opt out or say "no" to the disclosure of his financial information to nonaffiliated third parties (unless information is disclosed pursuant to § 38.2-613).

Under the new law, insurers and agents that do not wish to disclose information to affiliates or non-affiliated third parties may give a notice to consumers simply stating this fact, as long as the insurer or agent also explains what information it collects about the consumer and how the insurer or agent plans to keep that information confidential and secure and also explains that the insurer or agent makes other disclosures as permitted by law.

Current law allows insurers and agents to give an abbreviated information practices notice instead of the long version provided the insured is told he may get the long version if he wants it. This is still the case for medical record information. However, under the new law, an abbreviated or "short form" *financial* information practices notice may only be given to an *applicant*, not to a policyholder. This is different from the current law in that an abbreviated information practices notice in the past could be given to applicants and policyholders.

Also, a new provision in the new law states that an *agent* does not have to give an information practices notice as long as the insurer gives it and as long as the agent does not disclose any personal information to someone other than the insurer or its affiliates. An exception is also made if the agent discloses information that is allowed to be disclosed under § 38.2-613. However, if the agent *collects* information from an outside source, such as getting an MVR or a credit report, either the agent or the insurer will have to give the information practices notice at the time the information is collected.

Under current law, insurers and agents may only share information with their affiliates for certain reasons (such as marketing an insurance product) without getting written authorization from the insured. Under the new law, however, financial information may be shared with affiliates for any reason (such as marketing the affiliate's products) without getting the insured's permission or without giving the insured the right to opt out of the disclosure.

Under current law, insurers and agents may share financial information (not medical record or privileged claim information) with nonaffiliated third parties in connection with marketing products as long as an opt-out is given. The new law will be basically the same, except that financial information may be shared with nonaffiliated third parties without an opt-out if this is being done pursuant to a joint marketing agreement or if the third party is using the information to market the insurer's own products.

Current law pertaining to medical record information and privileged claim information will remain the same in that the individual's authorization must be obtained before this type of information may be shared (with certain exceptions allowed in § 38.2-613).

Chapter 519 (Senate Bill 1102)

SB 1102 adds §§ 38.2-221.2 to the Provisions of a General Nature Chapter and amends §§ 38.2-1301.1, 38.2-1306.1, 38.2-1320.4, 38.2-1320.5, 38.2-1333 (Reports, Reserves and Examinations); § 38.2-3127.1 (Life Insurance); § 38.2-4235 (Health Services Plans); and § 38.2-5508 (Risk-Based Capital for Insurers). SB 1102 conforms provisions concerning the confidential treatment of information regarding insurance companies held by the State Corporation Commission, and standardizes the circumstances when such information may be disclosed by the Commission. Disclosures may generally be made: (i) to a regulatory official of any state or country; (ii) to the National Association of Insurance Commissioners (NAIC), its affiliate, or its subsidiary; or (iii) to a law-enforcement authority of any state or country. Disclosures by the Commission shall not constitute a waiver of confidentiality of information. The measure also provides that information denominated in writing as confidential by a federal regulator and received by the Commission pursuant to GLBA shall be excluded from subpoena or public inspection. The Commission may provide a federal regulator with information with respect to any insurance business that is an affiliate or agent of a depository institution or financial holding company if the federal regulator agrees in writing to maintain such information in confidence and to take all reasonable steps to oppose any effort to secure its disclosure.

This bill also specifies that the Commission is not prohibited from (i) using confidential information in furtherance of any regulatory or legal action; (ii) publishing any decisions, orders, findings, opinions or judgments; or (iii) publishing any final report or any other report containing aggregated findings, provided that such reports, decisions, orders, findings, opinions or judgments shall not disclose any such confidential information.

INSURANCE AGENTS AND CONTINUING EDUCATION BILLS

Chapter 32 (House Bill 1648)

HB 1648 amends § 38.2-1871 in the Continuing Education Article of the Insurance Agents Chapter to add an additional means for a resident agent to qualify for exemption based upon age and experience. Under this new exemption, which will apply for the first time in the 2001-2002 biennium, a resident agent who is at least 65 years old and who will have held a Virginia license continuously and without interruption for no fewer than the immediately preceding four years by the end of the biennium may be exempt upon furnishing proof of the following: (i) having held equivalent license authority in Virginia for at least 20 of the preceding 30 years; and (ii) that any unlicensed period during the past 30 years was not the result of a license revocation or termination by the Commission pursuant to §§ 38.2-1832 or 38.2-1869.

Chapter 350 (Senate Bill 1088)

SB 1088 amends § 38.2-1867 in the Continuing Education Article of the Insurance Agents Chapter, to require the Virginia Insurance Continuing Education Board to approve continuing education courses and programs of instruction, including "technical courses or agency management and operations courses."

Chapter 706 (Senate Bill 913)

THREE EFFECTIVE DATES – SEE BELOW

SB 913 incorporates the reciprocal agent licensing provisions of the NAIC Producer Licensing Model Act that are necessary to comply with GLBA (the Gramm-Leach-Bliley Financial Services Modernization Act, Public Law 106-102). The measure also updates current laws, makes them more consistent with the laws of other states, and clarifies internal inconsistencies. Specific changes include (i) consolidating six currently restricted licenses into one limited life and health license; (ii) consolidating five currently restricted licenses into one limited property and casualty license; (iii) consolidating five types of credit insurance licenses into one new license; (iv) creating new specific nonresident license types to allow for full reciprocal licensing with other states; (v) creating a new "personal lines" license aimed primarily at those entering the insurance business and customer service representatives at insurance companies and insurance agencies who, while involved in sales, deal only with personal lines; (vi) creating a new "life and annuities" license and a new "health" license; (vii) liberalizing reciprocity for licensing nonresident agents based upon their qualifications in their home state; (viii) making the grounds upon which a license may be denied, suspended or revoked more consistent with the grounds utilized in other states; (ix) making continuing education requirements fully reciprocal for agents and consultants who provide satisfactory certification that they have satisfied the level of continuing education required in their home state; and (x) moving requirements for reinsurance intermediaries and managing general agents into Chapter 13. Among other changes not mandated by GLBA, the measure repeals the 45-hour prelicensing study course requirement and changes the current appointment fee to an appointment processing fee applicable to each transaction, regardless of whether the appointment is successfully processed. The statutory maximum for the appointment fee is raised from $15 to $25.

SB 913 has variable effective dates, as described below:

1. **THE ACT (THAT IS, <u>ALL</u> OF SB 913) IS EFFECTIVE ON SEPTEMBER 1, 2002, <u>EXCEPT</u> AS OTHERWISE SPECIFIED.**

2. **Therefore, all of the provisions that are REPEALED under SB 913 are repealed effective September 1, 2002.**

3. **THE FOLLOWING PROVISIONS ARE EFFECTIVE ON JULY 1, 2001:**

- **§ 13.1-400.3** Removal of requirement for filing actual bond - companies
- **§ 38.2-1220** Removal of requirement for filing actual bond - reciprocals
- **§ 38.2-1804** Blank forms (adds reference to "the insured")
- **§ 38.2-1805** Deletes "combination" and adds definition of "home service"
- **§ 38.2-1809** Makes section applicable to all "licensees"
- **§ 38.2-1810** Makes section applicable to all "licensees"
- **§ 38.2-1826** Expands what must be reported to the Commission
- **§ 38.2-1831** Expands grounds for Commission to take action vs. an agent or agency
- **§ 38.2-1833** Modifies appointment termination requirements, and creates appointment billing dates and penalties for late payment of appointment fees.
- **§ 38.2-1834** Modifies appointment renewal fee payment dates and creates penalties for late payment of renewal fees.
- **§ 38.2-1834.1** New section regarding notification of appointment termination by insurer, immunities, confidentiality, and penalties.
- **§ 38.2-1836.1** New section clarifying Commission's authority to contract with others to perform certain ministerial functions regarding licensing.
- **§ 38.2-1842** Expands what must be reported to Commission re: Consultants
- **§ 38.2-1843** Expands grounds for Commission to take action vs. a consultant
- **§ 38.2-1867** Expands grounds for C.E. Board to withdraw approval of courses.
- **§ 38.2-1868.1** Clarification of provision - no substantive change
- **§ 38.2-1870** Clarification of provision - no substantive change
- **§ 38.2-1871 C** Clarification of provision - no substantive change
- **§ 38.2-1872** Clarification of provision - no substantive change
- **§ 38.2-1874** Clarification of provision - no substantive change
- **§ 38.2-4008** Removal of requirement for filing actual bond - burial societies
- **§ 38.2-4806** Clarification of provision - no substantive change
- **§ 38.2-4807** Clarification of provision - no substantive change
- **§ 38.2-4809** Clarification of provision - no substantive change
- **§ 38.2-4815** Clarification of provision - no substantive change

4. THE FOLLOWING PROVISIONS DO NOT TAKE EFFECT UNTIL JANUARY 1, 2003 (BEGINNING A NEW C.E. BIENNIUM):

- **§ 38.2-1866** Changes to recognize splitting of life and health and property and casualty licenses
- **§ 38.2-1871 A** Changes to recognize elimination of prelicensing study course
- **§ 38.2-1871 B** Changes to recognize splitting of life and health and property and casualty licenses

The Bureau will, between now and the effective dates of various major changes in the agent licensing process, communicate the changes in more detail through the medium of Administrative Letters.

LIFE AND HEALTH BILLS

Chapter 22 (Senate Bill 955)

SB 955 amends § 32.1-137.13 in Article 1.2 of Title 32.1 (Health), dealing with Utilization Review Standards and Appeals. This provision requires written notification to the treating provider within two working days of the decision, and further requires such notification to include instructions for the provider on behalf of the covered person to seek a reconsideration or the adverse decision. Under this bill, the notice must also include the contact name, address, and telephone number of the person responsible for making the adverse decision.

Chapter 34 (House Bill 1661)

HB 1661 amends § 38.2-508 in the Unfair Trade Practices Act (Chapter 5 of Title 38.2). The bill prohibits the consideration of the status of a victim of domestic violence as a factor in decisions regarding insurance underwriting, pricing, renewal, scope of coverage or claims payment. The bill applies to insurance defined in § 38.2-100 and classified in Title 38.2, Chapter 1, Article 2 (§ 38.2-101 et seq.). The bill does not apply to legal services plans (as provided in § 38.2-4400 et seq.) or to insurance classified in §§ 38.2-110 through 38.2-133.

The bill defines the term “domestic violence” as meaning the occurrence of one or more of the following acts by a current or former family member, household member as defined in §16.1-228, person against whom the victim obtained a protective order or caretaker:

a. attempting to cause or causing or threatening another person with physical harm, severe emotional distress, psychological trauma, rape, or sexual assault;

b. engaging in a course of conduct or repeatedly committing acts toward another person, including following without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

c. subjecting another person to false imprisonment; or

d. attempting to cause or causing damage to property so as to intimidate or attempt to control the behavior of another person.

The bill does not prohibit an insurer or insurance professional from asking about a medical condition or using medical information to underwrite or carry out its duties.

Chapter 64 (House Bill 2720)

HB 2720 amends the definition of “annuity” in § 38.2-106 (General Provisions Chapter) by providing that periodic payments may be made in "specified or calculable sums," in place of the current "fixed dollar amounts" requirement.

Chapter 99 (House Bill 1800)

HB 1800 amends § 38.2-3407.11, dealing with direct access to obstetrician-gynecologists, by permitting the consultation with the primary care provider to be done electronically, as opposed to requiring that it be by telephone, and by deleting wording under which the primary care physician determined the need for an office visit before the patient was permitted to visit the OB-GYN.

Chapter 102 (House Bill 1922)

HB 1922 amends §§ 38.2-3408 (Accident and Sickness Insurance Chapter) and 38.2-4221 (Health Services Plan Chapter). The bill was recommended by the Special Advisory Commission on Mandated Health Insurance Benefits. It adds “marriage and family therapists” to the list of mandated providers in §§ 38.2-3408 and 38.2-4221.

Chapter 110 (House Bill 2078)

HB 2078 amends § 38.2-5901 (Adverse Utilization Review Decisions Chapter) to clarify the Bureau’s authority to refund the $50 external review filing fee after it has been paid, rather than limiting the Bureau’s authority only to waiving the fee prospectively.

Chapter 114 (House Bill 2228)

HB 2228 amends §§ 38.2-5202 in the Long-term Care (LTC) Insurance Chapter. The bill will necessitate that the Commission’s LTC regulation be amended to address “disclosure of rating practices to consumers” in addition to the areas that are already required to be addressed by the regulation.

A second enactment clause requires the Joint Commission on Health Care (JCHC) and the Bureau of Insurance to monitor the implementation of the revisions of the LTC Model Regulations of the NAIC that deal with initial filing requirements and premium rate schedule increases. The JCHC and the Bureau must also document the experience that other states have with the revised regulation and make recommendations as to whether Virginia should adopt the revisions. The JCHC and the Bureau of Insurance must report to the House Corporations, Insurance and Banking Committee and the Senate Commerce and Labor Committee on the progress of their

study in an interim report to the 2002 Session of the General Assembly and in a final report to the 2003 Session.

Chapter 208 (House Bill 2678)

HB 2678 **repeals** current § 38.2-3407.4:1 of the Code of Virginia.

Chapter 242 (House Bill 2063)

HB 2063 adds § 38.2-3407.11:3 (Accident and Sickness Insurance Chapter) to the Code of Virginia relating to health insurance. The bill prohibits insurers from denying the issuance or renewal of coverage, or from canceling such coverage or from including any exception or exclusion of benefits based solely on the insured having a high risk of breast cancer or having had breast cancer, but having been cancer free for five years or more. This bill applies to all 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; policies or contracts designed for issuance to persons eligible for coverage under Medicare, or any other similar coverage under state or federal government plans; corporations providing individual or group accident and sickness subscription contracts; and HMOs providing a health care plan for health care services.

Coverage cannot be denied or cancelled solely because the insured has been diagnosed with a fibrocystic condition or a nonmalignant lesion, or has a family history related to breast cancer, or any combination of these factors.

The insured cannot be not be denied coverage or have coverage cancelled solely due to breast cancer if he/she has been cancer free for a period of five years or more prior to the date of application. If coverage is subject to § 38.2-3432.3 (Accident and Sickness Insurance), § 38.2-3514.1 (Accident and Sickness Insurance Policies), or § 38.2-3605 (Medicare Supplement Policies), then the provisions of those sections shall be controlling as to the extent of any preexisting conditions period.

Coverage for the benefits will have durational limits, deductibles, coinsurance factors, and co-payments that are the same as those imposed on general physical illness.

Insurers cannot consider routine follow-up care in determining a pre-existing condition, if the insured has been free of breast cancer for at least five years following completion of therapies, unless evidence of breast cancer is found during, or as a result of follow up care.

The bill applies to policies, contracts, or plans delivered, issued for delivery, reissued, extended or renewed or extended, or at any time when the any term of any policy, contract, or plan is changed or any premium adjustment is made.

The bill does not apply to short-term travel, accident-only policies, limited disease or specified disease policies except those providing coverage for cancer, nor to short-term non-renewable policies of not more than six months' duration.

Chapter 276 (House Bill 2042)

HB 2042 amends § 38.2-5903 (Adverse Utilization Review Decisions) to clarify that the statutory assessment to fund the Bureau's external review appeal process is to be levied only upon those carriers that are subject to § 38.2-5801 B of the Code.

Chapter 334 (House Bill 2654)

EFFECTIVE JULY 1, 2002

HB 2654 is a reenactment of 2000 House Bill 1176, which required the issuance of standardized prescription drug benefits identification cards if there is coverage for prescription drugs (inpatient or outpatient). That bill contained a second enactment clause that required reenactment by the 2001 Session of the General Assembly before the bill would be effective on July 1, 2002.

The bill enacts § 38.2-3407.4:2 (Accident and Sickness Insurance Chapter). Insureds, subscribers or enrollees must be provided a prescription benefit card, health insurance benefit card or other technology. The card or other technology must comply with the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect at that time or include at least certain data elements. The elements that must be included are the name or trademark of the insurer, corporation, or HMO or benefit administrator; the insured, subscriber or enrollee name and identification number; the telephone number for pharmacy benefit assistance; and the electronic transaction information required to electronically process a prescription claim.

The prescription benefit card, health insurance benefit card, or other technology must be issued to each insured, subscriber or enrollee and, when there are changes in the data elements listed in subsection A of §38.2-3407.4:2, the card must be reissued or the insured, subscriber or enrollee must be provided with corrective information required to electronically process a prescription claim.

Insurers, corporations or HMOs can comply with the bill by issuing a health insurance benefit card that contains data elements for prescription and non-prescription benefits.

The bill applies to individual or group accident and sickness insurance 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 HMO health care plans when the policy contract or plan includes coverage for outpatient prescription drugs.

The identification cards are not considered part of the evidence of coverage and are not required to be filed and approved by the SCC. The bill also applies to state employee health coverage and coverage provided by the medical assistance services plan (Medicaid).

The bill does not apply to short-term travel, accident only, or short-term non-renewable policies of more than 6 months' duration. The bill also does not apply to insurers, corporations or HMOs that operate or maintain their own pharmacies and dispense, on an annual basis, over 95% of prescription drugs or devices to their enrollees at their own pharmacies.

Compliance with federal law or regulation that requires prescription benefit data elements on a prescription benefit card or health insurance benefit card will be considered compliance with this bill.

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

Chapter 475 (House Bill 2704)

EFFECTIVE JULY 1, 2002

HB 2704 amends §38.2-3408 in the Accident and Sickness Insurance Chapter and §38.2-4221 in the Health Services Plan Chapter. The bill requires accident and sickness policies and health insurance plans that provide reimbursement for a service that can legally be performed by a licensed pharmacist to reimburse the pharmacist for certain services under certain conditions specified in the bill.

The services must be (i) performed for an insured for a condition under the terms of a collaborative agreement, as defined in §54.1-3300 (Professions and Occupations), between a pharmacist and the physician who is providing treatment to the insured or (ii) limited to the administration of vaccines for immunization.

The insurer or corporation may require the pharmacist, any pharmacy or provider that employs a pharmacist or collaborating physician to enter into a written agreement with the insurer as a condition for reimbursement.

The reimbursement under the collaborative practice agreement is not subject to §38.2-3407.7.

Chapter 663 (Senate Bill 1200)

SB 1200 adds § 38.2-3411.4 in the Mandated Benefits Article of the Accident and Sickness Insurance Provisions Chapter, and amends § 38.2-4319 (HMOs) to provide coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 (Health), and as prescribed in the bill for newborn children. The bill applies to 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; and HMOs. The bill applies to policies, contracts, or plans delivered, issued for delivery or renewed in Virginia on or after July 1, 2001.

The required coverage includes infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. The coverage includes any follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

The bill prohibits the abrogation of any obligations to provide coverage for hearing screening tests or any other hearing screening test or audiological diagnostic procedure pursuant to this section or any other law or regulation of the Commonwealth or of the United States or under the terms or provisions of any policies or plans issued, renewed, reissued or extended in the Commonwealth.

The bill does not apply to short-term travel, accident-only, limited or specified disease policies, or contracts designed for persons eligible for coverage under Title XVIII of the Social Security Act (Medicare), or any other similar coverage under state or federal governmental plans, or short-term nonrenewable policies of not more than six months' duration.

PROPERTY AND CASUALTY BILLS

Chapter 98 (House Bill 1773)

HB 1773 amends § 8.01-581-1, which sets forth definitions for actions alleging medical malpractice, by adding a definition for "physician" and expanding the definition of "health care provider" to include directors, officers, employees and agents of persons or entities defined as health care providers acting within the scope of employment.

Chapter 211 (Senate Bill 808)

SB 808 amends § 8.01-581.15 of the Civil Remedies Code by clarifying that when acts of malpractice occurred prior to August 1, 1999, the total amount recoverable may not exceed the limitation on recovery set forth in the statute when the act of malpractice occurred. In other words, if an act of malpractice occurred in June of 1999, the previous $1,000,000 cap (which was in effect at the time) would apply. The bill states that this provision is declarative of existing law. The reason for this bill is that some plaintiffs have argued that there is no cap for actions arising prior to August 1, 1999 because this time period was not specifically mentioned in the law when it was amended in 1999.

Chapter 218 (House Bill 1939)

HB 1939 amends § 38.2-2206 (Liability Insurance Policies) by adding a statement in subsection E providing that no action, verdict or release arising out of a suit brought by an insurer subrogated to the insured against an uninsured motorist shall give rise to any defenses in any other action brought in the subrogated party's name, including res judicata and collateral estoppel.

Chapter 280 (House Bill 2306)

HB 2306 modifies § 65.2-813.2 in the Workers' Compensation Act by removing the four-year limit on the duration of the insurance premium discount that workers' compensation insurers provide to employers instituting drug-free workplace programs. Currently, insurers are required to provide employers who institute such programs that satisfy the insurer's criteria with premium discounts of up to five percent for a total of no more than four years. This bill also requires that the employer institute *and maintain* a drug-free workplace program in order to get the credit.

Chapter 316 (House Bill 1760)

HB 1760 amends § 6.1-2.23 of the Consumer Real Estate Settlement Protection Act (CRESPA) by requiring that all funds deposited with a settlement agent must be deposited into a financial institution no later than the close of the *second* business day. Current law says that funds must be deposited no later than the close of the *next* business day.

Chapter 335 (House Bill 2657)

This bill modifies § 38.2-510 of the Unfair Claim Settlement Practices Act by prohibiting a repair facility from paying an insurer (and prohibits an insurer from accepting) any kickback, rebate, commission, thing of value, or other consideration in connection with an appraisal. The bill also prohibits making appraisals of the cost of repairing a damaged automobile unless the appraisal is based on a personal inspection by the repair facility or the insurer.

Chapter 512 (House Bill 2789)

HB 2789 amends § 6.1-2.23 of the Consumer Real Estate Settlement Protection Act (CRESPA) by clarifying the procedures for disbursing title insurance premiums. Title insurance premiums payable to title insurers and agents may be (i) held in the settlement agent's settlement escrow account, identified and itemized by file name or file number, as a file with a balance; (ii) disbursed in the form of a check drawn upon the settlement escrow account payable to the title insurer or agent but maintained within the settlement file of the settlement agent; or (iii) transferred within two business days into a separate title insurance premium escrow account, which account shall be identified as such and be separate from the business or personal funds of the settlement agent. These transferred title insurance premium funds shall be itemized and identified within the separate title insurance premium escrow account. The bill also permits exceptions of § 6.1-2.13 when the settlement agent holds funds in escrow pursuant to written instruction or agreement.

Chapter 564 (House Bill 2801)

HB 2801 amends § 38.2-2202 by permitting insurers to require written notification by the insured of any requests to reduce the level of uninsured motorist coverage carried by the insured.

Chapter 728 (House Bill 2424)

HB 2424 amends § 38.2-2226 (Liability Insurance Policies) by requiring insurers to give 30 days' notice of the reservation of rights letter to the claimant or the claimant's counsel when a civil action has been filed by the claimant. The court may allow such notice to be given fewer than 30 days prior to the trial date. Failure to give the notice within 30 days of the trial date, or such shorter period as the court allows, will result in a waiver of the insurer's defense based on a breach of the contract.