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June 4, 2004

Administrative Letter 2004-5

TO: All Insurers and Other Interested Parties

RE: Legislation Enacted by the 2004 Virginia General Assembly

We have attached for your reference summaries of certain statutes enacted or amended and re-enacted during the 2004 Session of the Virginia General Assembly. **The effective date of these statutes is July 1, 2004, except as otherwise indicated in this letter.** Each organization to which this letter is being sent should review the summaries 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. Copies of individual bills may be obtained at http://legis.state.va.us/. You may enter the bill number (not the chapter number) on the Virginia General Assembly Home Page, and you will be linked to the Legislative Information System. You may also link from the Legislative Information System to any existing section of the Code of Virginia. All statutory references made in the letter are to Title 38.2 (Insurance) of the Code of Virginia unless otherwise noted.

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 affecting insurance-related laws during the 2003 Session. Each organization is responsible for legal review of the statutes pertinent to its operations.

Cordially,

Alfred W. Gross
Commissioner of Insurance

AWG/met

Attachment

PROPERTY AND CASUALTY BILLS

Chapter/Bill Number **Page Number**

FINANCIAL REGULATION BILLS

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LIFE AND HEALTH BILLS

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AGENT LICENSING BILLS

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PROPERTY AND CASUALTY BILLS

Chapter 182 (House Bill 221)

This bill amends § 38.2-111 by adding a new class of insurance under subsection B of this section. “Miscellaneous casualty” is defined as insurance against liability and against loss, damage, or expense arising out of injury to the economic interests of any person. Miscellaneous casualty does not include any other statutorily defined class of insurance and does not include insurance that is contrary to law or public policy.

Chapter 288 (House Bill 609)

The bill amends § 38.2-2125 by requiring the flood insurance notice to state that information regarding flood insurance is available from the insurer as well as the agent or the National Flood Insurance Program and to advise the policyholder that contents coverage may be available with the flood policy for an additional premium. The provisions of this act apply to contracts delivered, issued for delivery, reissued, extended or renewed on and after October 1, 2004.

Chapter 300 (House Bill 818)

This bill amends § 38.2-2114 by prohibiting insurers from non-renewing a policy written to insure an owner-occupied dwelling solely because of one or more claims that were incurred more than 60 months immediately prior to the expiration of the current policy period.

Chapter 336 (Senate Bill 587)

This bill amends § 6.1-2.26 of the Consumer Real Estate Settlement Protection Act (CRESPA) by requiring the appropriate licensing authority to notify settlement agents of the provisions of § 17.1-223 when the settlement agent’s registration is renewed. An amendment to § 17.1-223 allows the person or entity submitting the deed or deed of trust conveying not more than four residential dwelling units to state on the first page of the document the name of the title insurance underwriter and the policy number or a statement that there is no title insurance in effect or a statement that the policy number is not available or is unknown.

Chapter 597 (Senate Bill 509)

This bill amends § 6.1-2.25 by authorizing licensing authorities to issue summonses and subpoenas in order to carry out the provisions of the Consumer Real Estate Settlement Protection Act (CRESPA). The bill also amends § 6.1-2.27 by stating that a final order

which imposes a penalty or orders restitution will have the force and effect of a circuit court decree upon certification of the order by the licensing authority. Section 6.1-2.27 is further amended to give the appropriate licensing authority the ability to issue restraining orders.

Chapter 745 (House Bill 898)

This bill adds a new section § 38.2-2127 to Chapter 21 (fire insurance policies). The bill requires an insurer to provide a written notice whenever it unilaterally changes the deductible on a policy written to insure an owner-occupied dwelling. The notice must state that the deductible has changed and explain how the new deductible will be applied. The law prohibits the insurer from changing the deductible except at renewal, and the law applies to policies renewed on or after October 1, 2004. **NOTE**: The new law is not limited to changes in the deductible because of the territory or location of the property. Consequently, if the insurer unilaterally changes the deductible because of the insured's loss history, for example, the new notice must be given.

Chapter 751 (House Bill 1007)

This bill adds a new section to Chapter 21 (§ 38.2-2127), which allows policies written to insure owner-occupied dwellings to exclude coverage for liability resulting from an injury caused by a dangerous or vicious animal owned by or in the care, custody, or control of the insured if the animal has bitten, attacked, or inflicted injury on a person or a companion animal. The risk must be specifically identified in the exclusion, and the exclusion must have the named insured's written consent, which must be executed before a notary public or witnessed by a disinterested person. Insurers must file with the Bureau uniform policy forms that will be used by the insurer to exclude the coverage. The insurer must make available to the Bureau of Insurance the documentation that substantiates the reason for the exclusion as well as the signed exclusion and evidence of the insured's consent. Insurers are not required to obtain the insured's written consent for subsequent renewals.

NOTE: The Bureau of Insurance does not consider a "disinterested person" to be the insurance agent, customer service representative, or any other insurance company representative.

Chapter 767 (House Bill 1342)

This bill amends § 38.2-517 by requiring insurers to disclose to the insured or claimant, prior to being referred to a third party representative in connection with an automobile glass claim, that the third party is not the insurer and is acting on behalf of the insurer. The bill also adds the requirement that if the third party representative has a financial interest in the recommended repair or replacement facility, this information must be disclosed to the insured or claimant at the time the recommendation is made. The bill further states that the notice of the right to choose must be made by the insurer or its third party representative at the time it recommends a repair or replacement facility or service.

Chapter 822 (Senate Bill 601) **Effective July 1, 2006**

The bill amends § 2.2-1839 and adds a new provision that allows certain physicians and community hospitals, effective July 1, 2006, to purchase medical malpractice liability insurance under a program administered by the Department of the Treasury's Risk Management Division. The bill also establishes a joint subcommittee to study issues relating to medical malpractice insurance.

Chapter 838 (House Bill 553)

This bill amends § 38.2-1906 by allowing insurers, other than workers' compensation insurers, to file with the Bureau of Insurance any rate or supplementary rating information that limits rate increases that would otherwise be applicable to renewal policies.

Chapters 896 and 931 (Senate Bill 687 and House Bill 1407)

These bills amend Chapter 50 of Title 38.2 as follows:

- Subsection B of § 38.2-5009 is deleted. This eliminates the authority of the Virginia Workers' Compensation Commission to award reasonable expenses, including attorneys' fees, to applicants who are denied admission to the Virginia Birth-Related Neurological Injury Compensation Program.
- The participating physician assessment and the participating hospital assessment are increased by $100 and $10,000 per year, respectively, for five years, to a maximum of $5,500 and $200,000 respectively. The non-participating physician assessment is being increased by $10 per year, for five years, to a maximum of $300 per year. The increases are scheduled to begin on January 1, 2005.

FINANCIAL REGULATION BILLS

Chapter 174 (Senate Bill 355)

This bill amends § 38.2-1230 to require prior written approval of material transactions, and timely disclosure of most other transactions, between a domestic reciprocal and a related party and, when the transaction is material to the reciprocal, between any two or more of the reciprocal's related parties. The measure requires the annual filing of a related parties' summary and that a reciprocal's surplus, following any dividends or distribution to any of the reciprocal's related parties, shall be reasonable in relation to the reciprocal's outstanding liabilities and adequate to its financial needs.

Chapter 175 (Senate Bill 372)

This bill amends §§ 38.2-4300, 38.2-4301 and 38.2-4302 to provide that, for purposes of health maintenance organization regulation, "net worth" and "capital and surplus" have the same meaning. Persons owning or having the right to acquire five percent or more of voting securities or subordinated debt of an entity applying for a license to establish or operate a health maintenance organization are required to disclose such fact when applying for a license.

Chapter 236 (House Bill 1327)

This bill amends § 38.2-3420 to exempt from regulation in Virginia any multiple employer welfare arrangement (MEWA) comprised only of banks and their employees that (i) is licensed as a MEWA by insurance authorities in a contiguous state; (ii) files a copy of its license or certificate of authority with the Commission; and (iii) has no more than 50 Virginia residents who are employees of its member banks enrolled in or receiving accident and sickness benefits as insureds, members, enrollees, or subscribers of the MEWA. “Bank” as used in § 38.2-3420 is defined as an institution that has or is eligible for insurance or deposits by the Federal Deposit Insurance Corporation (FDIC).

Chapter 254 (Senate Bill 535)

The bill adds § 38.2-3100.2 to authorize insurers who are licensed to write life insurance or annuities in Virginia to also issue funding agreements. Subsection B defines "funding agreements." Subsection C lists the permitted uses of funding agreements. Subsection D addresses accounting treatment of funding agreements. Subsection E states that a funding agreement does not qualify as life insurance, an annuity, or any other form of insurance defined or classified in Article 2 of Chapter 1 of Title 38.2, although it constitutes transacting an insurance business in the Commonwealth. Subsection F provides that in a liquidation of an insurer pursuant to § 38.2-1509, the holders of a funding agreement will receive the same priority of distribution as is already accorded to policyholders

Chapter 285 (House Bill 596)

This bill amends § 38.2-1603 of the Property and Casualty Guaranty Association Act (Act) to recognize the existence of Virginia Property and Casualty Insurance Guaranty Fund coverage for certain qualifying claims that have been assumed as direct obligations of the insolvent insurer prior to the insurer's being declared insolvent. The bill states that certain transactions, including routine reinsurance transactions and surplus lines transactions, are not novations that would establish a direct obligation of the insurer to the insured. The definition of "insolvent insurer" is expanded to include an insurer that is licensed in Virginia when the obligation with respect to the covered claim is assumed.

Chapter 313 (House Bill 1181)

This bill amends §§ 38.2-3220, 38.2-3221, 38.2-3222, and 38.2-3229 concerning annuity nonforefeiture requirements in order to recognize model provisions adopted by the National Association of Insurance Commissioners (NAIC) for its "Standard Nonforfeiture Law for Individual Deferred Annuities."

Provisions amended by the bill detail the manner in which an insurer must calculate the minimum nonforfeiture provisions for annuity contracts issued on or after July 1, 2005, and provide that insurers may elect to apply the provisions to specified contracts issued prior to that date. This bill establishes a formula that uses an index-based interest rate to determine the minimum nonforfeiture amounts for individual deferred annuity contracts issued on or after July 1, 2005. The bill also authorizes the State Corporation Commission (SCC) to adopt rules and regulations to implement the provisions and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts for which the SCC determines adjustments are justified.

Chapter 315 (House Bill 1186)

The bill amends §§ 38.2-4123, 38.2-4214, 38.2-4319, and 38.2-4509 and adds § 38.2-1315.1 to require every insurer to submit annually an actuarial opinion and supporting documents, including a summary of opinion or issues, memoranda, and work papers prepared in conformity with appropriate National Association of Insurance Commissioners (NAIC) annual statement instructions. The documents shall be privileged and confidential and not discoverable or admissible in a civil action. The new requirements apply to fraternal benefit societies, health services plans, health maintenance organizations, and dental or optometric services plans.

Chapter 668 (Senate Bill 156)

This bill creates a new Chapter 61 in Title 38.2 that establishes a regulatory system under which companies that provide dental plans only may be licensed.

LIFE AND HEALTH BILLS

Chapter 156 (Senate Bill 44)

This bill repeals the scheduled July 1, 2004 sunsetting of the mandated health insurance benefit that requires the same coverage for biologically-based mental illnesses as is provided for other illnesses, conditions or disorders.

Chapter 185 (House Bill 628) Emergency Legislation Effective March 19, 2004

This bill amends § 38.2-4306 and adds § 38.2-4320.1 relating to health maintenance organizations (HMOs) providing services to enrollees covered by medical assistance services or the Family Access to Medical Insurance Security (FAMIS) Plan. The bill removes the requirement that Medicaid HMOs provide a conversion privilege and include in the evidence of coverage a statement entitling any Medicaid recipient or FAMIS participant the right to convert his/her coverage to an individual contract and conform the requirements for the explanation of benefits for those participants to the standards prescribed in the state plan for medical assistance services and the FAMIS Plan (Title XIX or Title XXI of the Social Security Act, as amended). The requirements for an explanation of benefits otherwise addressed in Title 38.2 shall not apply to HMOs when contracting to deliver such services to the extent that the statutory requirements differ from the standards of the Department of Medical Assistance Services.

Chapter 425 (House Bill 322)

This bill amends § 38.2-3407.15 relating to fair business practices for retroactive denials by health insurance carriers. The bill prohibits a health insurance carrier from imposing a retroactive denial of payment or seeking recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim for which the retroactive denial is to be imposed or recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted. The amended bill applies to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004. .

Chapter 715 (Senate Bill 618)

This bill amends § 38.2-3407.10 and § 38.2-5803 to allow insurance carriers to provide the required list of members of its provider panels in a form other than a printed document as long as the insurance carrier informs the purchaser or enrollee how a printed copy of the list may be obtained.

Chapter 761 (House Bill 1155)

The bill adds a new Chapter 61 to Title 38.2, which recognizes and authorizes Virginia's participation as a compacting state in the Interstate Insurance Product Regulation Compact (Compact) and provides that Virginia is a compacting state. The Compact is intended to (i) promote and protect the interest of consumers of individual and group annuity, life insurance, disability income, and long-term care insurance products; (ii) develop uniform standards for those insurance products; (iii) act as a central clearinghouse to review insurance products and advertisements; (iv) approve product filings and advertisements; (v) improve coordination of regulatory resources and

expertise among state insurance departments regarding uniform standards and review of relevant insurance products; (vi) create the Interstate Insurance Product Regulation Commission; and (vii) perform other related functions consistent with state regulation of the business of insurance. This bill also appoints the Commissioner of Insurance as the Commonwealth's representative to the Interstate Insurance Product Regulation Commission.

Chapter 771 (House Bill 1404)

This bill amends § 38.2-3525 to revise the requirements for coverage for dependents. The bill provides that, except for policies issued pursuant to § 38.2-3521.1 B, coverage under a group accident and sickness insurance policy may be extended beyond the current ages of 19 to 25 for dependent full-time students. When the insurer offers the option, a policyholder may elect coverage for children over the age of 25. The extension of coverage must be mutually agreed upon by the insurer and the group policy-holder.

Chapter 772 (House Bill 1408) Effective January 1, 2005

This bill amends § 38.2-3540.1 and §38.2-4319, making it applicable to health care plans and health maintenance organizations (HMOs). The bill requires group accident and sickness insurance policies and health care plans that cover policyholders with an average of at least 100 individuals on business days in the preceding 12-month period to provide, after a request, a complete record of the policyholder's medical claim experience or medical costs under the policy contract or plan. The record must cover all claims from the lesser of (i) the time when the policy, contract, or plan was issued or issued for delivery or, (ii) the time when the policy, contract, or plan was last renewed, reissued or extended. The bill requires that, along with the record of medical claims experience or medical costs, the policyholder must receive a summary of medical claims or medical costs in the most recent 24-month period, (ii) a listing of the number of insureds, subscribers or enrollees for whom combined medical claims or medical costs exceed $100,000 for the most recently available 12-month period and the preceding 12 months if not all ready provided, with information as to whether the enrollees are still enrolled, and provided that a policyholder and insurer may agree by contract to include amounts less than $100,000; and (iii) total enrollment in each membership type as of the end of the most recently available 12-month period. The bill also increases the number of days the record must be made available after request to 20 days, and requires the policyholder to request the record at least 45 days prior to renewal. The bill applies to health care plans and contracts delivered or issued for delivery, reissued or extended on or after January 1, 2005, or at any time when any term of the contract is changed or any premium adjustment is made.

Chapter 1015 (Senate Bill 337)

This bill amends § 2.2-3705, § 8.01-413, §§ 16.1-266 and 16.1-343, § 32.1-127.1:03, §§ 37.1-67.3, 37.1-134.9, 37.1-134.12, 37.1-132.21 and 37.1-226 through 37.1-230, and § 38.2-608 to comply with provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) and regulations on the disclosure and electronic transmission of protected health information.

Section 38.2-608 of Title 38.2 that relates to access to recorded personal information is revised to provide that direct disclosure to an individual may be denied if a treating physician or clinical psychologist has determined that the information may endanger the life or physical safety of the individual or another person or that a reference to a person might cause harm to the referenced person. If the disclosure to the individual is denied, the insured may request the insurance institution, agent, or support organization to either (i) designate an independent physician or clinical psychologist who, at the expense of such organization, must make a judgment regarding the release of the information, or (ii), if the individual so requests, at the insured's expense, make the information available to a designated physician or psychologist . The insurer must comply with the judgment.

AGENT LICENSING BILLS

Chapter 460 (House Bill 1057)

This bill amends §§ 9.1-102 and 9.1-143, § 16.1-77, § 19.2-149, §§ 38.2-1800, 38.2-1824, 38.2-2411, 38.2-2412, and § 58.1-3724. The bill adds §§ 9.1-185 through 9.1-199.4, §§ 38.2-2412.1 and 38.2-2412.2 and repeals §§ 19.2-152.1 through 19.2-152.1:7, and §§ 38.2-1865.6 through 38.2-1865.13. Effective July 1, 2005, the SCC will no longer license surety bail bondsmen. Surety bail bondsmen will be licensed by the Department of Criminal Justice Services. Surety bail bondsmen licenses in effect with the SCC shall be void after June 30, 2005.

Chapter 784 (House Bill 363)

This bill amends § 38.2-1800 and repeals § 38.2-4415 regarding the sellers of legal services plans. The bill also amends § 59.1-200 and adds Chapter 34.1 to Title 59.1. The bill transfers the responsibility for regulating the sellers of legal services plans from the SCC's Bureau of Insurance to the Department of Agriculture and Consumer Services.