COMMISSIONER OF INSURANCE

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BUREAU OF INSURANCE

April 30, 1987

ADMINISTRATIVE LETTER 1987-7

TO: All Insurance Companies, Prepaid Health Care Plans, and Health Maintenance Organizations

RE: Legislation enacted by the 1987 Session of the General Assembly of Virginia

Attached are summaries of certain statutes enacted or amended and reenacted by the General Assembly of Virginia during the 1987 Session.

The effective date of these statutes is July 1, 1987 EXCEPT as otherwise indicated in the attachment.

Each organization to which this letter is being sent should review the attachment carefully and see that notice of these laws is directed to the proper persons (including its licensed representatives) to insure that appropriate action is taken to effect compliance with these new legal requirements. Please note that this document is a summary of legislation and is neither a legal review and interpretation nor a full description of legislative amendments made to insurance-related laws during the 1987 Session. Each organization is responsible for legal review of the statutes pertinent to its operations.

Sincerely yours,

Steven T. Foster
Commissioner of Insurance

STF:bt
Attachment

PROPERTY AND CASUALTY INSURANCE

Senate Bill 158

Requirement for lenders to accept binders as evidence of insurance

This bill amends the Insurance Code by adding § 38.2-205.1 providing that a lender engaged in making loans on one to four family residences cannot unreasonably refuse to accept temporary insurance contracts (binders) as evidence that the property is insured.

Senate Bill 441

Recovery of damages for loss of use of vehicle

This bill amends § 8.01-66 of the Civil Remedies Code, relating to the recovery of damages for loss of use of a motor vehicle, by deleting "per diem" in reference to the cost of hiring a comparable substitute vehicle. This is a correction of an omission from a bill passed by the 1986 General Assembly. Companies will again be required to pay the full reasonable cost of the substitute vehicle including mileage charges.

Senate Bill 618

Medical Malpractice J.U.A.

This bill amends the provisions of the Medical Malpractice Joint Underwriting Association in Chapter 28 of the Insurance Code. The bill eliminates the requirement that the medical malpractice J.U.A. be totally self-supporting and reduces the stabilization reserve fund charge from one-half to one-third of the premium. Under this bill, only the preliminary organizational assessments would be returned to the member insurers upon dissolution of the J.U.A. While the retrospective rating plan would continue, the amount of money in the stabilization reserve fund would constitute a cap on retrospective premium charges. Any deficiency would be covered by member insurers which in turn would recover such costs through a credit on premium taxes.

Senate Bill 620

Medical Malpractice J.U.A. - Stabilization Reserve Fund

This bill amends § 38.2-2807 of the Insurance Code by changing certain provisions relating to the J.U.A.'s stabilization reserve fund. The bill provides for monies in the fund to be held in a separate restricted cash account under the sole control of an independent fund manager instead of being held in trust by a corporate trustee. The bill also allows the monies in the fund to be used for the purpose of reimbursing the association for expenses, taxes, licenses, and fees which are allocable to the stabilization reserve fund as well as for paying any retrospective premium charges due.

Virginia Insurance Guaranty Association

This bill amends the provisions of the Virginia Property and Casualty Insurance Guaranty Association to make that chapter of the Insurance Code (Chapter 16) generally consistent with the revised NAIC Model. Two amendments to the NAIC model are not included in this bill. First, claims for unearned premiums are not limited to $10,000 as they are in the NAIC model. Second, the deductible for unearned premiums is not increased to $100 as it was in the NAIC Model. This bill also amends the definition of "covered claim" to now include subrogation claims within that definition.

The major NAIC model changes that are in this bill include:

(1) Financial guaranty insurance products and credit enhancements are excluded from coverage.

(2) "Covered claims" shall not include punitive damages, or return of premium under any retrospective rating plan.

(3) The Association shall have the right to recover the amount of any covered claim paid by the Association to any person who has a net worth in excess of $50 million. Such recovery shall also apply to affiliates of the insolvent insurer.

(4) Persons will have to exhaust their recovery rights under any governmental insurance or guaranty program before seeking recovery from the Association and the Association's liability shall be reduced by the amount of such other recovery.

(5) The Association's obligation to inform the Commission of insurers that may be insolvent is eliminated. In its place, the Association would now be able to "(i) make recommendations to the Commission for the detection and prevention of insurer insolvencies, and (ii) respond to requests by the Commission to discuss and make recommendations regarding the status of any member insurer whose financial condition may be hazardous to the policyholders or the public."

House Bill 1125

Liability insurance in motor vehicles

This bill amends § 38.2-2205 of the Insurance Code by adding a provision which provides that the collision coverage provided to a named insured, in connection with the business of selling, leasing, repairing, servicing, storing or parking motor vehicles, shall in certain cases include persons other than the named insured and his employees as additional insureds when such other persons have no other valid and collectible insurance unless, in the case of a leased vehicle, such person receives written disclosure warning that coverage is not provided.

House Bill 1128

Unfair claims settlement practices on self-insured taxicab owners

This bill amends Title 56, the Public Service Companies Code by adding new § 56-303.1 which makes certain provisions of the Unfair Claim Settlement Practices Act applicable to

House Bill 1130

Regulation of taxicabs in localities

This bill amends § 56-291.3:7 of the Public Service Companies Code by specifying that any local ordinances or regulations imposed on taxicab operators shall not impose regulatory requirements relating to unfair discrimination beyond those set forth in § 56-303.1 or the financial requirements for being self-insured beyond those set forth in § 56-299. This bill also provides that it shall not affect or control the authority of local governments to establish liability insurance requirements for self-insurance programs.

House Bill 1234

Claim reporting

This bill amends the Insurance Code by adding § 38.2-2228.1 which requires all liability claims for personal injury or property damage made against policies insuring commercial entities to be reported to the Commission. The reports shall be on forms prescribed by the Commission and shall include:

1. Claims by the type of coverage;
2. The amount of all reserves established in connection with such claims and all adjustments thereto, updated on a quarterly basis until final settlement or judgment;
3. The amount paid by the insurer in satisfaction of the settlement or judgment;
4. The total number of claims and the average amount of each claim;
5. Attorney's fees and expenses paid by the insurer in connection with such claim or defense to the extent these amounts are known; and
6. Any other relevant information which the Commission may require that is consistent with the provision of the bill.

Rate service organizations designated by the Commission may file the claim report for individual companies. The term "commercial entity" is defined to include sole proprietorships, partnerships, corporations, unincorporated associations, the Commonwealth, and various local governing bodies. The Commission may also require the filing of individual claim information in addition to the aggregated reports.

Additional information on the regulatory requirements pursuant to HB 1234 will be forthcoming.

House Bill 1235

Cancellation, nonrenewal, reduction in coverage

This bill amends § 38.2-231 of the Insurance Code by requiring insurers of certain commercial insurance policies to provide written notice of reduction in liability coverage for personal injury or property damage (including policies which contain as a part thereof personal injury or property damage coverage) as well as notice for an increase in the rate for such coverage of more than 25%. Notice of such reduction of coverage or rate increase must be given at least 45 days prior to its effective date and must comply with similar types

of provisions required for cancellations and non-renewals. However, the provisions relating to a reduction in coverage only apply when the rates for such coverage are subject to §38.2-1912. The bill also permits the Commission to order an insurer to pay the insured any overpayment of premium if the Commission finds that the notice was not proper. Section 38.2-231 is amended to state that if the insurer does not give proper notice, coverage will remain in effect until 45 days after notice is mailed or delivered unless the insured obtains a replacement policy or agrees to cancel sooner. If the insured accepts the changed policy, the reduction in coverage or rate increase shall take effect on the day after expiration or the day after acceptance of the change whichever is later. Finally, a one-year records retention provision has been added.

The notice requirement is waived in certain situations where the insurer cannot obtain sufficient information to provide notice or if the notice is waived by the insured. This requirement also does not apply to reduction in coverage for an entire line or class of business.

The provisions of § 38.2-231 were also amended to clarify that the requirements relating to notices of cancellation or refusal to renew also now apply to policies which contain as a part thereof personal injury or property damage coverage.

The bill also amends § 38.2-1904 by requiring rates to consider Virginia loss experience as long as it is relevant and actuarially sound. Other data may be used when it is considered relevant and actuarially sound. In addition to considerations including past and prospective loss experience and expenses, separate consideration is also to be given to the loss reserving practices, standards, and procedures utilized by the insurer. Investment income from all sources, including surplus, is also to be taken into consideration. Section 38.2-1904 is also amended to allow the Commission to consider estimates when actual experience or data does not exist.

Section 38.2-1905.1 has been added which requires the Commission to submit an annual report to the General Assembly (with a copy to the Attorney General's office) to indicate both the level of competition among insurers for lines or sublines of insurance defined in §§ 38.2-117 and 38.2-118 (including combination policies) insuring a commercial entity and the availability and affordability of those lines or sublines. The Commission is to indicate the lines or subclassifications where competition does not appear to be an effective regulator of rates. The Commission is to then hold hearings on those lines or subclassifications to determine whether competition is, in fact, an effective regulator of rates for those particular lines or subclassifications. In making this determination the Commission may consider such factors as the number of insurers actually writing the line or subclassification and their respective market shares, the ease of entry into the market, the extent of rate differentials among insurers writing the line or subclassification, and whether there is a pattern of excessive rates relative to losses, expenses, and investment income.

Section 38.2-1905.2 is also added which requires insurers who write commercial liability coverage (including combination policies) to file supplemental reports on any line or subclassification designated in the annual report required under new § 38.2-1905.1. Designation in the annual report is conditioned on there being a reasonable cause to believe that competition may not be an effective regulator of rates. The supplemental reports shall be on a form prescribed by the Commission and may include at the direction of the Commission:

4. Direct losses paid identified by such period as the Commission may require;
5. Number of claims paid;
6. Direct losses incurred during the year, direct losses incurred during the year which occurred and were paid during the year, and direct losses incurred during the year which were reported during the year but were not yet paid;
7. Any loss development factor used and supporting data thereon;
8. Number of claims unpaid; and
9. Such other relevant information as may be required by the Commission.

Section 38.2-1906 is amended to clarify that where the Commission has found, after hearing, that competition is not an effective regulator of rates, the provision of § 38.2-1912 shall be in force. Additionally, if § 38.2-1912 is in force, specific supporting information must be filed with every proposed rate revision. This information shall be on a form prescribed by the Commission and may include:

1. Number of exposures;
2. Direct premiums written;
3. Direct premiums earned;
4. Direct losses paid identified by such period as the Commission may require;
5. Number of claims paid;
6. Direct losses incurred during the year, direct losses incurred during the year which occurred and were paid during the year, and direct losses incurred during the year which were reported during the year but were not paid;
7. Any loss development factor used and supporting data thereon;
8. Number of claims unpaid;
9. Loss adjustment expenses paid identified by such period as the Commission may require;
10. Loss adjustment expenses incurred during the year, loss adjustment expenses incurred during the year for losses which occurred and were paid during the year, and loss adjustment expenses incurred during the year for losses which were reported during the year but were not paid;
11. Other expenses incurred, separately by category of expense, excluding loss adjustment expenses;
12. Investment income on assets related to reserve and allocated surplus accounts;
13. Total return on allocated surplus;
14. Any loss trend factor used and supporting data thereon;
15. Any expense trend factor used and supporting data thereon; and
16. Such other information as may be required by rule of the Commission, including statewide rate information presented separately for Virginia and each state wherein the insurer writes the line, subline or rating classification for which the rate filing is made and which the Commission deems necessary for its consideration.

Section 38.2-1908 is amended to provide that the supporting information required under subsection A1 of § 38.2-1906 must be filed with the Commission when an insurer files a modification to increase the rate charged under a rate service organization's filing if such filing is subject to the 60-day prefiling requirement set forth in § 38.2-1912. When an insurer files a modification to decrease the rate charged under such filing, the Commission shall determine what additional information shall be required.

Additional information on the regulatory requirements pursuant to HB 1235 will be forthcoming.

House Bill 1403

Medical expense payments under motor vehicle liability insurance policies

This bill amends subsection A of § 38.2-2201 of the Insurance Code by changing from one year to two years the length of time after an accident that medical expenses may be incurred in order for the expenses to be covered under the policy.

This bill also amends § 38.2-2202 so that the notice which is required to be given regarding medical expense coverage complies with the changes made in § 38.2-2201.

LIFE AND HEALTH INSURANCE

Senate Bill 379

Insurer reimbursement for services by physical therapists

This bill amends §§ 38.2-3408 and 38.2-4221 of the Insurance Code to include physical therapists as a health care provider entitled to reimbursement as provided for in the mandated benefits article of the accident and sickness chapter and in the health services plan chapter. The additional language provides that if a physical therapist performs a service that is covered by a policy, payment cannot be denied by the insurer or health services plan because it was performed by a physical therapist, if the physical therapist is licensed to provide the service in Virginia.

Senate Bill 458

Assignment of interest in benefits under burial insurance policies

This bill amends § 38.2-4021 of the Insurance Code to provide that a certificate of membership in a burial society may be revocably assigned to pay for a pre-need contract which is described in § 11-24 as being an agreement for the sale of personal property to be used for final disposition or funeral services or burial services where the personal property is not to be delivered or services rendered until the death of the person for whom the services are to be furnished.

Senate Bill 459

Insurer reimbursement for services by professional counselors

This bill amends §§ 38.2-3408 and 38.2-4221 of the Insurance Code to include "professional counselor" in the mandated benefits article of the accident and sickness chapter and in the health services plan chapter. The additional language provides that if a professional counselor performs a service that is covered by a policy, payment cannot be denied by the

Section 38.2-1909 is amended to allow the Commission, when it reviews rates, to consider whether the loss experience and other factors within the Commonwealth are being properly used to determine rates, not just whether rates are excessive, inadequate, or unfairly discriminatory.

Section 38.2-1910 is amended to parallel the changes made in § 38.2-1909. The Commission may suspend, and subsequently disapprove, a proposed rate if, among other things, it finds that loss experience and other factors particular to Virginia have not been properly used to determine the rates.

Section 38.2-1912 is amended to require the pre-filing of rates 60 days before the effective date instead of 30 days before the effective date. The Attorney General's office is to be given notice of such filing by the insurer and a certification of this is to be given to the Commission. Section 38.2-1912 is also amended to permit the Commission to require the pre-filing of rates if Virginia loss experience and other factors specifically applicable to Virginia are not being properly used to determine rates.

Section 38.2-2003 is amended to require each insurer, which writes business to which Chapter 20 applies, to give notice to the Attorney General's office that a rate filing has been made and to certify such to the Commission. Additionally, each insurer shall be required to provide certain supporting information with its rate filing. This information shall be on a form prescribed by the Commission and may include:

1. Number of exposures;
2. Direct premiums written;
3. Direct premiums earned;
4. Direct losses paid identified by such period as the Commission may require;
5. Number of claims paid;
6. Direct losses incurred during the year, direct losses incurred during the year which occurred and were paid during the year, and direct losses incurred during the year which were reported during the year but were not paid;
7. Any loss development factor used and supporting data thereon;
8. Loss adjustment expenses paid identified by such period as the Commission may require;
9. Loss adjustment expenses incurred during the year, loss adjustment expenses incurred during the year for losses which occurred and were paid during the year, and loss adjustment expenses incurred during the year for losses which were reported during the year but were not paid;
10. Other expenses incurred, separately by category of expense, excluding loss adjustment expenses;
11. Investment income on assets related to reserve and allocated surplus accounts;
12. Total return on allocated surplus;
13. Any loss trend factor used and supporting data thereon;
14. Any expense trend factor used and supporting data thereon; and
15. Such other information as may be required by rule of the Commission, including statewide rate information presented separately for Virginia and each state wherein the insurer writes the line, subline or rating classification for which the rate filing is made and which the Commission deems necessary for its consideration.

Changes have also been made in § 38.2-2005 which parallel the changes made in § 38.2-1904.

insurer or health services plan because the service was provided by a professional counselor if the service can legally be performed by a licensed professional counselor.

The bill also amends §§ 38.2-3408 and 38.2-4221 by deleting the requirement that clinical social worker services be specifically contracted for under a policy or contract in order for coverage of treatment by a clinical social worker to be required.

House Bill 1078

Reimbursement for services by clinical social workers

This bill amends §§ 38.2-3408 and 38.2-4221 in the mandated benefit article of the accident and sickness chapter and in the health services plan chapter of the Insurance Code. The bill deletes the language requiring that insurance coverage for clinical social work services be specifically contracted for under a policy and that coverage must be made available to policy purchasers; therefore the section now provides that if a clinical social worker performs a service that is covered by a policy, payment cannot be denied by the insurer or health services plan if the clinical social worker is licensed to provide the service in Virginia.

House Bill 1252

Long-Term Care

This bill creates a new chapter in the Insurance Code. Long-term care policies, both group and individual, will be subject to all provisions of the Insurance Code relating to insurance policies and certificates generally except Chapter 34, Article 2 and Chapter 36, which deal with mandated benefits and medicare supplement insurance respectively. The authority of the State Corporation Commission to issue regulations to establish specific standards for policies is set out. The regulations are to recognize the experimental nature of long-term care insurance.

The definition of "long-term care insurance" includes policies or riders that offer coverage for at least 12 consecutive months for necessary "diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal care, mental health or substance abuse services provided in a setting other than an acute care unit of a hospital." The definition includes the contracts issued by traditional insurers, health service (Blue Cross/Blue Shield) plans, fraternal benefit societies, health maintenance organizations (HMOs) cooperative nonprofit life benefit companies or mutual assessment life, accident and sickness insurers. HMOs, cooperative nonprofit life benefit companies and mutual assessment life, accident and sickness insurers can apply to the Commission for approval to offer long-term care policies.

Long-term care policies are prohibited from having provisions that would allow the insurer to terminate a policy based on the age, or deterioration of the mental or physical condition of the insured. The policies are also prohibited from having an additional waiting period if a policy is replaced by another policy with the same company.

A preexisting condition may not be excluded from coverage for more than 12 months. The authority of the SCC to extend the limitation period is specifically included. Companies are allowed to underwrite policies according to their established standards for long-term care policies and to request a complete health history.

Any individual long-term care policies that, in the Commission's opinion, could be considered limited benefit policies must meet the loss ratio standards that apply to all limited benefit policies. However, existing loss ratio standards that do not specifically include long-term care policies cannot be used to evaluate any other long-term care policy.

A full and complete outline of coverage is required to be delivered to an applicant for individual long-term care insurance when the insured applies. Insurers that sell policies on a direct response basis must provide the outline no later than when the applicant receives the policy. Certificates issued under group policies must also include an outline of coverage. In addition, a copy of a long-term care consumer's guide published by the SCC must be provided to the insured at the time of delivery.

"Free-Look" provisions are also included in the legislation. These provisions give individuals purchasing long-term care insurance policies an opportunity to review the policies and return them within a designated period if the policies are not in accordance with their needs. Individual policies must provide at least a 10-day period. Direct response solicitations require a thirty-day free look period for individual and group policies. The existence of this provision must be prominently displayed on each policy or certificate.

TECHNICAL AND EDITORIAL INSURANCE CODE REVISIONS

Senate Bills 490 and 491

Insurance Code Revision

These bills amend several sections in the Insurance Code to clarify changes or to correct minor typographical and editorial errors resulting from changes made during the 1986 recodification.

PREMIUM TAXES AND ASSESSMENTS

Senate Bill 598 and House Bill 1396

Taxation of certain insurance companies

These bills are identical. They amend and add sections to the Insurance Code relating to the license tax on certain insurance companies, health service plans, the Virginia Property and Casualty Insurance Guaranty Association, the Virginia Life, Accident and Sickness Insurance Guaranty Association and Fraternal Benefit Societies.

The major changes and additions in these bills are:

1. Fraternal Benefit Societies will now be subject to the annual assessment for the expense of maintaining the Bureau (§ 38.2-400);

2. The Virginia Property and Casualty Guaranty Association has been amended to provide a tax credit for assessments paid by member insurers. Under § 38.2-1606 A(3a), the Association shall issue a certificate of contribution to each insurer paying an assessment. Section 38.2-1611.1 provides that the assessment paid to the Association may be deducted from the amount of the member's premium tax liability. The amount that may amortized in each calendar year succeeding the calendar year of issuance has been set to an amount not to exceed 0.05 of 1 percent of the member's direct gross premium income for the classes of insurance in the account for which the member insurer is assessed;

3. The certificate of contribution in the Virginia Life, Accident and Sickness Insurance Guaranty Association has also been amended. The amount that may be amortized in each calendar year succeeding the calendar year of issuance has been set at an amount not to exceed 0.05 of one percent of the direct gross premium income of the member insurer for the classes of insurance in the account for which the member insurer is assessed (§ 38.2-1709);

4. The Virginia Life, Accident and Sickness Insurance Guaranty Fund and the Virginia Property and Casualty Insurance Guaranty Fund now parallel each other in terms of the certificate of contribution and any resultant tax write-off;

5. The premium income received by cooperative non-profit life benefit companies from policies not requiring legal reserves is now subject to a tax of one percent on its collected gross premiums.(§ 38.2-1709);

6. The statutory provisions governing subsidiaries of insurance companies are now made applicable to health service plans licensed under Chapter 42 (§ 38.2-4214). Section 38.2-4225 has been repealed. The provisions of § 38.2-1336 shall apply to any insurance holding company as defined in § 38.2-1322 that controls a nonstock corporation subject to this chapter;

7. Section 38.2-4216 has been repealed and replaced by § 38.2-4216.1. The new provisions are as follows:

   A. Subsection A states that a nonstock corporation licensed under Chapter 42 shall make available an open enrollment program, as per this section, to all citizens of this Commonwealth;

   B. Subsection B defines the terms "comprehensive accident and sickness contracts" and "open enrollment contracts." Coverage must be offered to all individuals and members of groups of 49 or fewer. Group contracts must allow conversion to an individual policy, the level of coverage to be determined by the Commission;

   C. Subsection C states that coverage cannot be denied for an individual because of age, health history, employment status or industry classification or, for a member of an eligible group, because of industry or job classification of the group, or the age, health history or insurability of any member of the group (including dependents);

   D. Subsection C also states that the open enrollment program shall be made available on a 12-month basis. If available on less than a 12-month basis, credit

prior to the open enrollment policy coverage;

E. Subsection C also states that the subscription charge for open enrollment contracts shall be reasonable in relation to benefits and deductibles, as determined by the Commission;

F. Subsection D requires the advertisement of the availability of the open enrollment program at least 12 times per year, in a newspaper or newspapers of general circulation. The general content and format of these advertisements shall be approved by the Commission;

G. Subsection E allows the Commission to prescribe minimum standards to govern the contents of open enrollment policies. The option of purchasing comprehensive major medical coverage must be made available to open enrollment subscribers. These minimum standards may be applied to group conversion policies;

H. Subsection F states that an open enrollment program may only be discontinued upon 24-month advance written notice to the Commission;

I. Subsection G states that a nonstock corporation licensed under this chapter shall provide other public services to the community, including health-related support and training to subscribers for whom such support and training may reduce their health-related care and expense.

8. Information, in addition to the annual statements now required of the Blues, would also have to be filed with the S.C.C. This additional annual statement must include: a) the number of Virginia subscribers by contract type (the contract types are enumerated); b) subscriber income and benefit payments by type of contract; c) expenditures for public services in addition to that spent for open enrollment (§§ 38.2-4217);

9. The license application fee for the Blues has been eliminated (§ 38.2-4222);

10. The license tax in § 58.1-2500 of the Taxation Code is now applicable to the Blues, in lieu of all other state and local license fees and/or taxes and state income taxes (§ 38.2-4226);

11. Section 58.1-2501 of the Taxation Code has been amended as follows:

A. This section applies the annual license tax to corporations defined in § 38.2-4201 and § 38.2-4501;

B. This section also adjusts the tax rate applicable to accident and sickness, property and casualty, life and title insurance. The rate through taxable year 1988 is 2 3/4% of subscriber fee income or direct gross premium income. From taxable year 1989 on, the rate is 2 1/4% of subscriber fee income or direct gross premium income;

C. This section applies a tax rate of .75 of 1 percent of direct gross subscriber fee income to subscription contract plans defined in § 38.2-4201 and § 38.2-4501

this subsection shall commence on or before April 15, 1988;

12. Section 58.1-2520 of the Taxation Code has been amended to require all nonstock corporations licensed under Chapters 42 (Health Services Plans) and 45 (Dental Services Plans) of the Insurance Code to make a declaration of its estimated tax liability. Any insurance company or nonstock corporation with a taxable year of less than twelve months shall make a declaration in accordance with regulations prescribed by the Commission.

HEALTH MAINTENANCE ORGANIZATIONS

Senate Bill 382

Tax exemption on HMO property

- This bill amends § 58.1-608 of the Taxation Code so that personal property purchased by nonprofit health maintenance organizations is exempt from retail sales and use tax.

INSURANCE COMPANIES

House Bill 905

Extraordinary dividends

This bill amends § 38.2-1330 of the Insurance Code relating to standards for transactions between insurers and affiliates. The amendment lessens regulatory oversight of the activities of holding companies by limiting the circumstances that would constitute extraordinary dividends and commission approval for payments of such dividends.

House Bill 1100

Financial reserves in insurance special funds

This bill amends § 6.1-2 of the Banking and Finance Code and § 38.2-400 of the Insurance Code as they relate to the SCC's financial reserves in the Banking and Insurance Special Funds. The amended language clarifies the authority of the SCC to maintain a reasonable margin in the nature of a reserve for the expenses of operating the Bureaus of Financial Institutions and Insurance.

House Bill 1152

Insurer's limitation of risks for municipal bond insurance

This bill amends § 38.2-208 of the Insurance Code to provide that, for municipal bond insurance, the amount of any single risk shall be measured by the average annual debt service. The purpose of this bill is to permit the licensure of monoline financial guaranty insurers in Virginia. Due to the current interpretation of § 38.2-208 (prior to the enactment of this legislation) and the financial structure of monoline insurers, such insurers have been effectively prohibited from operating in Virginia on a licensed basis.

This bill amends the Insurance Code by adding a new section, § 38.2-1306.1, that will make confidential all financial analyses of insurance companies submitted to the Commission by the National Insurance Commissioners' Insurance Regulatory Information System (IRIS).

House Bill 1406

Certificate of authority

This bill amends the Corporations Code (Title 13.1), relating to foreign stock and nonstock corporations. The new language allows the Clerk of the Commission to reenter the certificate of authority of a foreign stock or nonstock corporation who has had its certificate of authority suspended or revoked, provided that particular criteria are met. A foreign corporation shall also be allowed to obtain a certificate of authority from the Commission in the event that it changes the state or country of its incorporation. Previously, an amended certificate of authority could only be obtained if the corporate name was changed.

The bill also amends § 38.2-1040 of the Insurance Code, relating to the refusal, suspension or revocation of a company's license to transact the business of insurance. This amendment adds to the provisions by which the Commission may refuse to issue, suspend or revoke the insurance license of any domestic, foreign or alien insurer. The new language adds a provision relating to the revocation of a corporation's certificate of authority in Virginia.

AGENTS/INSURANCE CONSULTANTS (FINANCIAL PLANNERS)

Senate Bill 492

Agents chapter revision

This bill extensively amends Chapter 18 (Insurance Agents) of the Insurance Code. Among the many changes are:

1. The definition of the terms "agent", "licensed agent", and "appointed agent" are clarified (§ 38.2-1800).

2. There is a new chapter-wide definition of the phrase "solicit, negotiate, procure, or effect" (§ 38.2-1800).

3. It is now to be prohibited for anyone but a duly licensed and appointed agent to claim to be a representative of, authorized agent of, agent of, or other term implying a contractual relationship with an insurer (§ 38.2-1801).

4. Separate "lending institution" licenses are created for employees of lending institutions seeking licensing for certain limited lines, and prelicensing requirements for such agents are specified (§ 38.2-1811).

5. Rules governing when and to whom commissions may be paid have been clarified (§ 38.2-1812).

6. Changes have been made to allow for exemption from examination requirements for those applying for non-resident licenses, and to require satisfaction of all prelicensing requirements for those moving into Virginia from another jurisdiction (§§ 38.2-1817 and 38.2-1836).

7. Changes are also made to allow for future implementation of an automated testing system for agent licensing (§ 38.2-1817).

8. Examination and licensing fees have been separated and specified (§§ 38.2-1817 and 38.2-1819).

9. Additional requirements for documentation to be furnished by partnerships and corporations applying for licensing have been added (§ 38.2-1822).

10. The appointment process enacted in 1985 has been substantially modified, providing a specific date from which time limits commence and granting a longer period of time to comply with the revised requirements of the statute, negating adverse consequences of mail delays, etc. (§ 38.2-1833).

11. Specific time limits for notification to both the agent and the Commission when an agent's appointment is terminated have been added (§ 38.2-1834).

12. All agents with partial qualifications granted under prior law will have until July 1, 1988 to become fully qualified. All partial qualification licenses will be revoked effective July 1, 1988.

House Bill 1046

Financial Planners

This bill amends both the Insurance and the Corporations (securities) Codes to bring the majority of financial planners under the existing reach of state regulation. What was formerly limited to property and casualty consultants under the Insurance Code has been expanded to create life and health consultants as well, and specific licensing requirements have been set forth for each. In addition, a disclosure statement would be required if the insurance consultant could receive a commission for products sold in addition to the fee for service received for the insurance advice. The bond requirement in the existing statute has been deleted.

The Virginia Blue Sky Laws have been amended and include a requirement that investment advisors registered with the United States Securities and Exchange Commission must now also register at the state level (many investment advisors were previously exempt from state registration). This change will bring many investment advisors/financial planners under all of the regulatory requirements of the state. More information on the securities portion of the bill can be obtained from the SCC Division of Securities and Retail Franchising (804/786-7751).

Group self-insurance pools for political subdivisions

This bill amends the Counties, Cities, and Towns Code by adding a new section, § 15.1-503.4:2.1, that gives the Commonwealth or any agency of the Commonwealth the authority to exercise any of the powers given to a political subdivision in connection with group self-insurance pools. However, any agency of the Commonwealth must have prior written consent from the Governor to join a self-insurance pool if the Division of Risk Management has established an insurance plan providing the same type of insurance coverage.

House Bill 1022

Insurance pool for underground storage tanks

This bill amends the Housing Code (Title 36) by authorizing the Board of Housing and Community Development to promulgate regulations developed by the state water control board concerning underground storage tanks. It also amends the Waters of the State, Ports and Harbors Code (Title 62.1) by expanding the authority of the state water control board to oversee undergound storage tanks. Additionally, it allows owners or operators who are unable to meet the financial responsibility requirement to establish an insurance pool, the formation of which would be subject to the approval of the SCC. Finally, this bill establishes the Virginia underground storage tank fund.

House Bill 1168

Risk Retention

This bill adds a new chapter to the Insurance Code relating to the regulation of risk retention groups and purchasing groups. This bill is essentially the same as the recently adopted NAIC model. Certain modifications were, however, required to conform the model to Virginia and to clarify ambiguities. The general areas where the Commission will have regulatory authority include:

1. financial solvency;
2. false and deceptive practices;
3. policy content, as regards companies selling to purchasing groups;
4. compliance with motor vehicle financial responsibility laws;
5. licensing of agents, and
6. payment of premium taxes.

House Bill 1216 (Effective July 1, 1987, except §§ 38.2-5002 through 38.2-5014 which are effective January 1, 1988)

Birth-related neurological injury compensation act

This bill adds a new chapter to the Insurance Code. The purpose of this bill is to create a Birth-Related Neurological Injury Compensation Program. The rights and remedies granted under this program replace all other rights and remedies. Compensation under the program will be determined by the Industrial Commission. For the purpose of this chapter, a "birth

related neurological injury" means injury to the brain or spinal cord of an infant that has been caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living.

Funding for the program will be derived from:

1. Participating hospitals ($50 per delivery for the prior year, not to exceed $150,000 per hospital in any one twelve-month period);

2. Participating physicians ($5,000 per year);

3. All other licensed practicing physicians ($250 per year); and

4. Liability insurers subject to a maximum .25% of net direct written premiums. However, liability insurers are secondary to the other funding sources and may recover any assessment made against them through policy surcharges, rate increases, or combination of surcharges and rate increases. The method of recovery shall be at the discretion of the Commission.

The provisions that become effective on July 1, 1987 will permit the necessary organizational activities to be completed in 1987. The Program will not become operational until January 1, 1988. The bill only applies to claims for birth-related neurological injuries occuring in Virginia on and after January 1, 1988.

TITLE INSURANCE

House Bill 1025

Prohibiting title insurance kickbacks

This bill amends § 38.2-4614 of the Insurance Code as it relates to the prohibition against payment or receipt of title insurance kickbacks. This bill now provides that no person shall be in violation of this section solely by reason of ownership in a bona fide title insurance company, agency, or agent as opposed to referring solely to those who own stock in the company.

INSURANCE INFORMATION AND PRIVACY PROTECTION

Senate Bill 561

Insurance information in criminal investigation

This bill adds a new provision to paragraph 6 of § 38.2-613 of the Insurance Code which is part of the Privacy Protection Act. This new provision directs insurance institutions, agents and support organizations to comply with requests by law enforcement agencies for information relating to criminal investigations. Information released pursuant to this new provision shall be treated as confidential information. The releasing entity shall not inform any insured or claimant that information has been provided to a law enforcement agency.

TORT REFORM

Senate Bill 402

Limitation on punitive damages

This bill amends the Civil Remedies and Procedure Code by adding § 8.01-38.1 which places a $350,000 cap on the amount of punitive damages that can be awarded in personal injury cases.

Senate Bill 403

Exemption from jury service

This bill amends §§ 8.01-341 and 8.01-341.1 of the Civil Remedies and Procedure Code by limiting the classes of people who may claim exemption from serving on juries in civil and criminal cases.

Senate Bill 404 and House Bill 1088

Limitations on liability of corporate officers

These identical bills amend the Corporations Code by limiting the liability of corporate officers and directors in proceedings brought by or on behalf of shareholders of the corporation or brought by or on behalf of members of the corporation. The limit of liability would apply except where the officer or director had engaged in willful misconduct or a knowing violation of criminal law. The limit of liability is set at the lesser of (i) the monetary amount specified in the articles of incorporation or (ii) the greater of $100,000 or the amount of cash compensation received during the year immediately preceding the act or omission for which liability is imposed.

Senate Bill 405 and House Bill 1094

Statute of limitations in medical malpractice

These identical bills amend the Civil Remedies and Procedure Code by adding a provision which limits the time within which a person on behalf of a minor can bring action for medical malpractice. The statute of limitations is set at two years from the date of the act or omission giving rise to the cause of action, with some exceptions being granted.

Senate Bill 486

Insurance for employees of local governments

This bill amends § 15.1-7.3 of the Counties, Cities and Towns Code as it relates to insurance for employees of local governments. The amended language allows the local government, if it so chooses, to provide for its retired officers and employees to be eligible for any group life, accident, and health insurance programs that it provides for its present officers and

House Bill 1052

Statute of limitations

This bill amends § 8.01-243 of the Civil Remedies and Procedure Code by including in the statute of limitations for personal actions any action for damages resulting from fraud.

House Bill 1083

Certification of merits of pleadings

This bill amends § 8.01-271.1 of the Civil Remedies and Procedure Code by requiring attorneys to certify as to the merits of any pleadings or motions which are filed by them. The bill also imposes sanctions upon attorneys who file frivolous lawsuits or who otherwise misrepresent the merits of any pleadings or motions.

House Bill 1084

Immunity of members of local government

This bill amends the Counties, Cities, and Towns Code by adding a section which grants immunity to members of local governing bodies for lawsuits arising from the conduct of their affairs except where such lawsuit involves the appropriation of funds or is the result of intentional or willful misconduct or gross negligence.

House Bill 1533

Limit on liability for members of transportation districts

This bill amends § 15.1-1364 of the Counties, Cities and Towns Code which pertains to the limit of liability for members of transportation districts. The bill expands the definition of "liability policy" to include any program of self-insurance administered by the Virginia Division of Risk Management.