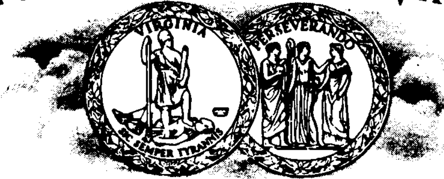
STEVEN T. FOSTER
COMMISSIONER OF INSURANCE

COMMONWEALTH OF VIRGINIA



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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

May 19, 1995

Administrative Letter 1995-6

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

RE: **Legislation enacted by the 1995 Virginia General Assembly**

We have attached for your reference summaries of certain statutes enacted or amended and re-enacted during the 1994 Session of the Virginia General Assembly. **The effective date of these statutes is July 1, 1995, except as otherwise indicated in this letter.** 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 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 1995 Session. Each organization is responsible for legal review of the statutes pertinent to its operations.

Please note that two bills included in this year's summary reference the addition of a new Chapter 54 (§ 38.2-5400 et seq.) to the Code of Virginia. The Virginia Code Commission will determine the correct citation for each of the new chapters of the Code of Virginia, and the results will be evident when the official code compilation is published by the Michie Company later this summer. Until then, House Bill 1973 and Senate Bill 724 both contain references to Chapter 54 of the Code of Virginia. These bills are contained in the Life and Health and Financial Regulation of Insurance sections, respectively.

Sincerely yours,

Steven T. Foster
Commissioner of Insurance

ALL BILLS ARE EFFECTIVE JULY 1, 1995 UNLESS OTHERWISE NOTED

PROPERTY AND CASUALTY INSURANCE

Chapter 3 (House Bill 220)

This bill amends § 38.2-2114 by prohibiting insurance companies from non-renewing policies written to insure owner-occupied dwellings solely because of any claim resulting primarily from natural causes. This means that regardless of the number of claims resulting primarily from natural causes, the insurer is prohibited from non-renewing solely for that reason.

Sections 38.2-2114 and 38.2-2212 are also amended to establish certain requirements for insurance companies that non-renew private passenger auto and homeowners policies due to adverse credit information. Insurers must give the insured a notice stating that the non-renewal is based on a consumer report, and the notice must provide the name and address of the institution reporting the credit information. The insurance company must also advise the insured that he can obtain a free copy of the credit report and that he has 10 days to question the accuracy of the report. If the insured sends a written request questioning the credit report, the policy will remain in effect during the time the insurance company is verifying the accuracy of the credit information. The bill provides that a homeowners policy may not be non-renewed until 30 days after the accuracy of the credit report has been verified and communicated to the insured. Under an automobile policy, the non-renewal may not become effective until 45 days after the accuracy of the credit report has been verified and communicated to the insured. The insured must respond to any company inquiry within 10 days of mailing and, if the insured fails to cooperate, the insurance company may terminate the investigation and non-renew the policy after providing 15 days written notice to the insured. The provisions of this bill will apply to non-renewals effective on or after July 1, 1995.

Chapter 302 (House Bill 1788)

This bill amends § 38.2-5001 which establishes definitions for the Virginia Birth-Related Neurological Injury Compensation Program. The definition of "participating hospital" is amended to include employees of the hospital who are acting in the course and scope of their employment provided those employees

are not physicians or nurse midwives who are eligible to qualify as participating physicians under the program.

Chapter 226 (House Bill 1926)

This bill amends §§ 38.2-2217 and 46.2-498 by allowing insurance companies to offer a reduction in premiums for drivers under 55 years old who voluntarily attend and satisfactorily complete a driver improvement clinic. Drivers must take these clinics every two years in order to continue to be eligible for the premium credit. Premium reductions for motor vehicle accident prevention courses available to drivers 55 and older are still required to be offered by insurance companies, and these courses must be taken every three years in order to continue to be eligible for the credit.

Chapter 119 (House Bill 1951)

This bill amends § 38.2-2701 by expanding the definition of "basic property insurance" written through the Virginia Property Insurance Association (VPIA). The revised definition allows the VPIA to write additional lines of insurance as recommended by the VPIA's board of directors and approved by the Commission. The VPIA requested this statutory change to provide broader coverage. The VPIA is planning to offer coverage on a replacement cost basis. It also plans to make available a liability endorsement and a theft endorsement on owner-occupied dwellings.

Chapter 121 (House Bill 1989)

This bill amends §§ 46.2-440 and 46.2-441 by allowing a nonresident to show proof of future financial responsibility from an insurance company or other state-authorized entity providing insurance and authorized or licensed to do business in the nonresident's state of residence. Proof of future financial responsibility must be in the amounts required by § 46.2-472. This bill attempts to correct problems that were created by the legislative change made in 1993 when the Maryland Automobile Insurance Fund was added as an insurance company authorized to do business in Maryland. The Maryland Automobile Insurance Fund asked for this change in order not to be required to file the deposit as required in § 46.2-440.

Chapter 237 (House Bill 2217)

This bill adds § 65.2-813.1 to the Workers' Compensation Code which allows workers' compensation insurers to offer small deductible policies. Such policies must provide for the insurer to pay first dollar and then seek reimbursement from the policyholder. The bill also allows the insurer to cancel the deductible endorsement if the policyholder fails to reimburse the insurer for the deductible.

Chapter 476 (House Bill 2510)

This bill amends § 38.2-2206 (uninsured motorist insurance coverage) by changing the definition of "insured" to include wards and foster children of either the named insured or the spouse who are residents of the same household. The provisions of this act apply to all motor vehicle policies issued, renewed, or issued for delivery on or after July 1, 1995.

Chapter 175 (Senate Bill 726)

This bill amends Title 6.1 by adding a new section numbered § 6.1-2.9:6. The new code section prohibits lending institutions from requiring borrowers, who are refinancing a mortgage, to cancel the existing homeowners policy and obtain a new policy for the sole purpose of changing the effective date of coverage. An exception is made if the expiration date of the existing policy is within four months of the closing. The bill makes it clear that lending institutions are not prohibited from requesting a new policy when coverage under the existing policy is inadequate or if there is a concern over the financial soundness of the insurer or the services the insurer will provide.

Chapter 803 (Senate Bill 882)

This bill amends § 38.2-1902 (scope of chapter) by requiring the rates for automobile bodily injury and property damage liability insurance issued to petroleum tank truck carriers to be filed with the SCC Bureau of Insurance on a "file and use" basis. The bill also amends provisions in Titles 9, 46.2, 52, 56, and 58.1 pertaining to the regulation of motor carriers.

Chapter 267 (Senate Bill 888)

This bill adds a new section to the Workers' Compensation Code (§ 65.2-309.1). The new law creates a right of subrogation on behalf of an employer against proceeds recovered by an employee under the employer's uninsured or underinsured motorist coverage. The bill also allows the employer to deduct from medical, surgical, hospital, and funeral expenses incurred by the employer a proportionate share of such amounts paid by a plaintiff in any action brought by the employee. Section 38.2-2206, subsection I, is also amended to make reference to § 65.2-309.1.

Chapter 189 (Senate Bill 930)

This bill amends § 38.2-2206 by stating that any one named insured may reject additional uninsured motorist coverage, and such rejection will be binding upon all insureds under the policy. This section currently requires a policy of motor vehicle liability insurance to include uninsured motorists limits equal to the liability limits on the policy unless the insured rejects the higher limits. This change makes it clear that the rejection of the higher uninsured motorists limits by any named insured under the policy will be binding upon all insureds.

Chapter 652 (Senate Bill 1104)

This bill amends § 38.2-2204 by allowing insurers to exclude motor vehicle liability coverage that inures to the benefit of the Commonwealth under the provisions of the Virginia Tort Claims Act and a self-insurance plan established by the Department of General Services. This provision applies to state employees who, in the regular course of their employment, transport patients in their own personal vehicles.

LIFE AND HEALTH INSURANCE

Chapter 80 (House Bill 1715)

This bill amends § 38.2-4319 in the Health Maintenance Organizations Chapter, by adding § 38.2-3433 to the "sweep-in" provision. This clarifies that the small employer market premium and disclosure provisions apply to HMOs.

Chapter 745 (House Bill 1973)

This bill amends § 38.2-5300 in the Private Review Agent Chapter and adds a new Chapter 54 with §§ 38.2-5400 through 38.2-5409 titled "Utilization Review Standards and Appeals." Section 38.2-5400 in the new chapter contains definitions of "adverse decision", "covered person", "final adverse decision", "peer of the treating health care provider", "treating health care provider" or "provider", "utilization review entity" or "entity", and "utilization review plan" or "plan". Section 38.2-5401 provides that Chapter 54 does not apply to utilization review (UR) performed under contract with the federal government for patients eligible for Medicare, or under contract with a plan otherwise exempt pursuant to the Employee Retirement Income Security Act of 1974, or private review agents subject to Chapter 53, or under programs administered by the Department of Medical Assistance Services or administered under contract with that Department.

The bill requires that each entity establish standards and criteria for utilization review determinations with input from physician advisors representing major areas of specialty and certified by the boards of the various medical specialties. The standards are to be objective, clinically valid, compatible with established principles of health care, and flexible. A list of the physician advisors, their major areas of specialty, and the standards and established criteria must be provided to any provider upon request except as prohibited by copyright laws.

Section 38.2-5402 includes requirements regarding physician advisors and review staff including specialists and those authorized to approve UR determinations.

Section 38.2-5403 requires that the UR plan contain procedures for at least the following:

1. Review determinations;
2. Advance notice to patients of requirements for certification or pre-approval of care;
3. Advance notice that compliance with the review process is not a guarantee of benefits or payment;
4. The process of reconsideration and appeal; and
5. Ensuring confidentiality of patient-specific medical records and information.

Section 38.2-5404 requires a UR entity to provide free telephone access for patients and providers for at least 40 hours a week during normal business hours. The bill also requires the entity to have an adequate phone system to accept and record messages beyond normal business hours.

Section 38.2-5405 contains requirements for emergency care, extensions of care or hospitalization, and access to patient-specific medical records and information.

Section 38.2-5406 contains requirements for rendering adverse decisions. The bill requires notification within 2 work days when there is such a decision. The decision should include instructions for requesting reconsideration including a contact name, address, and phone number. Entities must make a good faith attempt to obtain information from providers prior to rendering an adverse decision.

Section 38.2-5407 requires each entity to have a process for reconsideration of an adverse decision.

Section 38.2-5408 requires an extensive appeals process for final adverse decisions, including a process for expedited appeals. Requirements for notification, review personnel, and opportunity for and presentation of additional information are included. The section does not apply to adverse decisions, reconsiderations, or final adverse decisions based only on the fact that benefits are not covered by the plan for the health care in question. The section also provides that insurers, health services plans, health maintenance organizations, or entities performing UR cannot end employment or a contractual arrangement, or otherwise penalize a provider for invoking the appeals process or advocating the interest of his patient "unless the provider engages in a pattern of filing appeals that are without merit."

Section 38.2-5409 requires entities to maintain written records of review procedures, staff qualifications, review criteria, number of complaints and their resolution, number and type of adverse decisions and reconsiderations, final adverse decisions and appeals, as well as procedures for the confidentiality of medical and personal information. Records are to be maintained at a location

accessible to Commission employees for 5 years, and are subject to examination by the Commission.

The Commission has no jurisdiction to adjudicate controversies arising out of §§ 38.2-5402, 38.2-5404, 38.2-5405, 38.2-5406, 38.2-5407, and 38.2-5408.

The Commission has the right to determine that an entity has adopted a review plan according to subsection A of § 38.2-5403, but has no jurisdiction to determine the propriety of the plan.

Chapter 446 (House Bill 1977)

This bill amends § 38.2-4312.1 in the Health Maintenance Organizations Chapter. It creates an exception in the freedom of choice requirements for pharmacies by declaring that in situations where an HMO wholly owns and operates a pharmacy or where a pharmacy is operated exclusively for the HMO, the HMO does not have to comply with the provision with regard to other pharmacies.

Chapter 522 (House Bill 2043)

This bill amends and reenacts §§ 38.2-3503, 38.2-3605, 38.2-4214 and 38.2-4319. The bill adds § 38.2-3514.1. The bill changes the allowable preexisting conditions period from two years to **one** year for individual policies. In the new § 38.2-3514.1, the bill provides that individual policies must credit the time a person was covered under previous individual or group policies providing hospital, medical and surgical or major medical coverage. The coverage must have been continuous for up to no more than 30 days prior to the new coverage. The bill also defines a preexisting condition provision as meaning a policy provision that:

> limits, denies, or excludes coverage for charges or expenses incurred during a 12-month period following the insured's effective date of coverage for a condition that during a 12-month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received within 12 months immediately preceding the effective date

of coverage or as to pregnancy existing on the effective date of coverage.

The bill does not apply to short-term travel, accident only, limited or specified disease contracts, long-term care insurance, short-term non-renewable policies or contracts of not more than six months' duration, which are subject to nonmedical underwriting or minimal underwriting; individual open enrollment policies or contracts issued pursuant to § 38.2-4216.1 to persons previously insured under a group health insurance policy or contract issued by another unaffiliated company, who due to health status, would be eligible for individual coverage only through open enrollment, or Medicare supplement insurance.

Chapter 467 (House Bill 2304)

This bill amends § 38.2-3407.7 in the Accident and Sickness Insurance Chapter, § 38.2-4209.1 in the Health Services Plan Chapter and § 38.2-4312 in the Health Maintenance Organizations (HMO) Chapter. The bill repeals §§ 38.2-3407.8, 38.2-4209.2, and 38.2-4312.2 relating to ancillary services providers.

The bill provides that insureds or members have the right to select, without limitation, pharmacies that have previously notified the insurer, health services plan, or HMO that they agree to accept reimbursement for their services at the same rate as preferred providers as payment in full, including copayments. Each insurer, health services plan, and HMO must establish a system to permit electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and must promptly verify the reimbursement terms.

The bill also provides that in no event shall a person receiving a covered pharmacy benefit from a nonpreferred provider or nonparticipating provider, that has submitted a reimbursement agreement, be responsible for fees beyond the copayment and the normal reimbursement for preferred providers.

The bill provides that for the purposes of §§ 38.2-3407.7, 38.2-4209.1 and 38.2-4312.1, a prohibited condition or penalty includes (i) denying immediate access to electronic claims filing to a nonpreferred pharmacy that has complied with the section's requirements of a direct service agreement or a preferred provider agreement or (ii) requiring a person to make a point of service payment beyond what is imposed for preferred providers.

A pharmacy that wants to be covered by the bill must complete and deliver a direct service agreement or preferred provider agreement to the insurer, health services plan, or HMO if requested to do so. The agreement

must be delivered within 30 days of receipt. Any pharmacy or ancillary provider that does not complete and deliver the agreement within 30 days will not be covered by the section until an agreement is completed and delivered.

The bill also provides that the section is not applicable to any pharmaceutical benefit covered by a health care plan when the benefits are obtained from a pharmacy wholly owned and operated by, or exclusively operated for, the HMO providing the health care plan.

The Joint Commission on Health Care (JCHC) is to conduct a three-year study of how the availability and quality of ancillary medical services are affected by managed care. The findings are to be included in JCHC reports to the Governor and the General Assembly in 1996, 1997, and 1998.

Chapter 689 (House Bill 2337)
Chapter 650 (Senate Bill 1035)

These companion bills establish a Virginia Medical Savings Account Plan (plan). ***Upon passage of federal legislation authorizing the components of the plan,*** state agencies that are named in the bill, including the State Corporation Commission Bureau of Insurance, are to take action to implement the plan.

The bill requires the Department of Medical Assistance Services (DMAS) to develop and implement a plan to utilize medical savings accounts for the provision of primary, acute care, and long-term care to the working poor, and those eligible for Medicaid. DMAS must also develop a plan and apply for a waiver from the Health Care Financing Administration (HCFA) to implement a demonstration project.

The bill requires the Bureau of Insurance to provide the General Assembly, DMAS and the Department of Workers' Compensation a report on available plans or policies providing high deductible indemnity health policies or other insurance mechanisms for providing low-cost catastrophic care. The Bureau is also to advise on the inclusion of the essential health services used as the basis for managed care commercial health insurance.

The Department of Workers' Compensation is to develop and implement a plan to utilize medical savings accounts for provision of acute care to employees eligible for workers' compensation, and is to cooperate with the Department of Taxation to develop a system for voluntary employer contributions to medical savings accounts, and reasonable tax deductions.

The Department of Taxation is to develop, and present to the General Assembly, a system for refundable tax credits that is consistent with federal law and regulation. The system is to include a sliding scale for the working poor and innovative use of tax credits for employers and health care providers that participate in the plan.

The plan is to include at least the following requirements for medical savings accounts: eligible participants, criteria for accounts, use of debit cards, educational programs, integration of existing coverage, refundable tax credits, a system for withholding amounts to be deposited in medical savings accounts, a system for calculating individual need, a system for tax credits for the working poor and for health care practitioners, a system for voluntary employer contributions, a cafeteria menu of insurance plans for high-deductible insurance policies, and any other specific provisions necessary.

The Joint Commission on Health Care is to monitor development of the plan and make recommendations to the various agencies. Periodic reports are to be provided to the Joint Commission from the state agencies involved in the plan, as the Joint Commission may require.

Chapter 345 (House Bill 2583)

This bill amends § 38.2-4300 in the Health Maintenance Organizations Chapter. The bill adds a definition of "emergency services" to the chapter. The term is defined to mean:

> those health care services that are rendered by affiliated or non affiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, or (ii) danger of serious impairment of the individual's bodily functions, or (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from non affiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended.

Chapter 537 (Senate Bill 553)

This bill adds § 38.2-3418.2 to the Code of Virginia and amends § 38.2-4319 in the Health Maintenance Organizations Chapter. The bill prohibits individual and group accident and sickness policies, health services plan contracts and health maintenance organization health care plans that provide coverage for diagnostic and surgical treatment of any bone or joint of the skeletal structure from excluding coverage for diagnostic and surgical treatment involving a bone or joint of the head, neck, face or jaw. The bill applies to policies, contracts, and plans delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1995. The bill also prohibits the imposition of coverage limits for bones or joints of the head, neck, face or jaw that are more restrictive than coverage limits for bones and joints of the skeletal structure if the treatment is required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

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

Chapter 182 (Senate Bill 801)

This bill amends § 38.2-4300 in the HMO chapter by amending the definition of "basic health care services" to provide that it does not apply when a health maintenance organization has contracted with the Commonwealth to furnish health services to recipients of medical assistance under Title XIX of the U.S. Social Security Act (Medicaid) pursuant to § 38.2-4320. The bill provides that basic health care services may vary to the extent necessary to meet the benefit standards prescribed by the state plan for Medicaid pursuant to § 32.1-325 of the Code of Virginia.

Chapter 259 (Senate Bill 805)

This bill amends § 38.2-3323, which provides for coverage for spouses and dependent children (including dependent handicapped children) under group life insurance contracts. The amendment makes the section consistent with a similar provision (§ 38.2-3409 B) applicable to group health insurance contracts by adding a provision clarifying the circumstances under which coverage will continue beyond the usual contractual limiting age for a dependent

handicapped child, including time limits for notification to the insurer of the continuance of such handicap and dependency.

Chapter 68 (Senate Bill 806)

This bill clarifies § 38.2-3405 (anti-subrogation provision) to indicate that coordination of benefits provisions in health insurance policies may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage.

Chapter 270 (Senate Bill 917)

This bill amends § 38.2-3412.1 in the mandated benefits sections of the Accident and Sickness Insurance Chapter. The bill provides that for the purpose of the mandate of coverage for mental health and substance abuse services, any expenses for outpatient treatment that may apply toward a deductible required by the policy or contract are not to count toward the outpatient visit benefit until the deductible has been met and the expenses for the visits are covered by the policy or contract.

Chapter 420 (Senate Bill 979)

This bill adds § 38.2-3407.9 to the Accident and Sickness Provisions Chapter and amends §§ 38.2-4214 in the Health Services Plan Chapter and 38.2-4319 in the Health Maintenance Organizations (HMO) Chapter. The bill provides that if a policy provides for ambulance services, any person providing ambulance services to a covered person must be reimbursed directly from the insurer, health services plan or HMO, <u>if there has been an assignment of benefits to the person providing the services</u>.

The bill defines "ambulance services" as meaning the transportation of any person by means of any ambulance, rescue or life-saving vehicle designed or used for the principal purpose of supplying resuscitation or emergency relief where human life is endangered. The term includes emergency medical services ambulances and mobile intensive care units.

FINANCIAL REGULATION OF INSURANCE

Chapter 843 (House Bill 1917)

This bill amends and reenacts § 38.2-5110 in the chapter concerning risk retention groups and purchasing groups. The bill adds a provision under which the Commission shall be deemed a state court of competent jurisdiction, independent of its Bureau of Insurance, in all judicial proceedings to enforce the provisions of Chapter 51 concerning risk retention groups and purchasing groups.

Chapter 321 (House Bill 2025)

This bill amends § 38.2-4135. Amendments in subsection A exempt from regulation under Chapter 45 of Title 38.2 any association, whether a fraternal benefit society or not, which was organized before 1880 if the members of the association are past or present members of the Armed Services or Sea Services of the United States and the provision of insurance and other benefits to members, their dependents or their beneficiaries is a principal purpose of the association.

The bill expands the exemption in subsection F to "orders" and "associations."

Chapter 789 (Senate Bill 724)

This bill adds risk-based capital provisions (RBC) in a new Chapter 54 of the Code of Virginia. The new RBC provisions require insurers, including life and health as well as property and casualty insurers, to maintain additional levels of surplus based upon the volume and the kinds of insurance transacted. Those insurers which fail to maintain the required levels of risk-based capital will be subject to special corrective orders issued by the Commission. The reports required by the RBC Act shall remain confidential. The requirements will take into consideration the individual insurer's operations, including the riskiness of investments, cash flow and type of insurance activity. States accredited by the National Association of Insurance Commissioners (NAIC) Accreditation Program are expected to adopt such legislation by January 1, 1997 if a state is to remain accredited.

Chapter 60 (Senate Bill 733)

This bill amends several general provisions dealing with the financial regulation of insurers. Sections 38.2-1046 and 38.2-1048 are amended to provide that assets placed on deposit with the State Treasurer of Virginia by an insurance company domiciled in Virginia shall be disbursed pursuant to the provisions of Chapter 15 of Title 38.2 in the event of liquidation, rehabilitation or conservation of an insurer. This amendment will ensure that all of the assets of the delinquent domestic insurance company are disbursed in a consistent and equitable manner.

This bill also amends §§ 38.2-1413, 38.2-1414, 38.2-1427.3 and 38.2-1432 to simplify and clarify the manner in which insurers are authorized to invest in common stock, preferred stock, debt obligations and other securities of a subsidiary. The amendments proposed will result in more reliable and consistent regulation because the applicable limitations on investments will be clearer to insurers and regulators.

The bill also amends § 38.2-2710 of the Code of Virginia to require residual market facilities, inspection services and joint underwriting associations subject to Chapter 27 to file annual financial reports in a form prescribed by the Commission, as other insurers are required to do.

This bill amends § 38.2-4811 to raise the minimum capital and surplus requirements for insurers approved under Chapter 48 of Title 38.2 to issue surplus lines insurance in the Commonwealth. The amendment provides a three-year phase-in period for less capitalized insurers to comply with the new requirements.

CREDIT PROPERTY INSURANCE (P&C)
CREDIT INVOLUNTARY UNEMPLOYMENT INSURANCE (P&C)
CREDIT LIFE INSURANCE (L&H)
CREDIT ACCIDENT AND SICKNESS INSURANCE (L&H)

Chapter 167 (House Bill 1901)

This bill amends §§ 38.2-233, 38.2-1814, 38.2-1824, 38.2-3727, and 38.2-3737. A new definition of "credit property insurance agent" has been added to § 38.2-1800, and a new restricted license has been created for a credit property insurance agent, meaning that agents who sell credit property insurance will no longer have to be licensed as full Property and Casualty agents. This means that those wishing to sell credit property insurance will not be required to take pre-licensing education, sit for an examination, or satisfy continuing education requirements.

The bill also changes from 25 days to 7 days the waiting period for the solicitation of credit involuntary unemployment insurance and credit life and credit accident and sickness insurance after the credit transaction.

A provision has also been added that allows joint credit accident and sickness insurance to be offered at a rate that is 165% of the rate applicable to individual credit accident and sickness insurance.

CONTINUING EDUCATION

Chapter 554 (Senate Bill 1125) - Emergency legislation effective 3/24/95

This bill amends §§ 38.2-1868 and 38.2-1869 by extending the end of the first continuing education biennium until 6/30/95. This bill does NOT extend an agent's time to comply in any manner other than by completing courses. Reciprocity requests, waiver requests, exemption requests, etc. are not given the additional time.

MISCELLANEOUS

Chapter 615 (Senate Bill 1049)

This bill amends § 38.2-401, the Fire Programs Fund by increasing the assessment on insurers from 8/10 of 1% to 1%. Therefore, the 1995 Fire Programs Fund assessment, based on 1995 calendar year direct gross premium income, due by March 1, 1996, will be 1% of such direct gross premium income.