COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

June 14,1996

Administrative Letter 1996-6

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

RE: **Legislation enacted by the 1996 Virginia General Assembly**

The State Corporation Commission (Commission) has recently appointed me Acting Commissioner of Insurance while the Commission considers a permanent replacement for Steven T. Foster. Commissioner Foster resigned effective April 30, 1996. 1 have served as Deputy Commissioner for Financial Regulation since 1989, and have been employed with the Bureau of Insurance since 1981.

We have attached for your reference summaries of certain statutes enacted or amended and re-enacted during the 1996 Session of the Virginia General Assembly. **The effective date of these statutes is July 1. 1996, except as otherwise indicated in this letter.** Each organization to which this letter is being sent should review the attachments carefully and see that notice of these laws is directed to the proper persons, **including appointed representatives,** to ensure that appropriate action is taken to effect. compliance with these new legal requirements. Please note that this document is a **summary** of legislation. It is neither a legal review and interpretation nor a full description of the legislative amendments made to insurance-related laws during the 1996 Session. Each organization is responsible for legal review of the statutes pertinent to its operations.

Sincerely yours,

Alfred W. Gross
Acting Commissioner of Insurance

NOTE: Except where otherwise indicated, all bills are effective 7/1/96.

LIFE AND HEALTH INSURANCE

Chapter 201 (House Bill 87) and Chapter 155 (Senate Bill 148)

This bill adds § 38.2-3414.1 in the Accident and Sickness Provisions Chapter, and amends §§ 38.2-4319 in the Health Maintenance Organizations Chapter. The bill provides that each insurer proposing to issue individual or group hospital or major medical policies, corporations proposing to issue individual or group subscription contracts, and HMOs providing health care plans must provide coverage for postpartum services if they provide coverage for obstetrical services.

The postpartum coverage is to include benefits for inpatient care and a home visit or visits in accordance with the medical criteria outlined in the most current version of, or update to, the current "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (Guidelines) or the "Standards for Obstetric-Gynecological Services" prepared by the American College of Obstetricians and Gynecologists (Standards). The coverage is to incorporate any changes to the-Guidelines or Standards within six months of the publication of changes or any official amendment.

The requirements of the new law apply to all policies, contracts and plans delivered, issued for delivery, reissued or extended on or after July 1, 1996, or at any time the premium is adjusted. The new law does not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, or Medicare supplement policies.

The bill also amends § 32.1-325 to require that payment for medical assistance for pregnant women receiving services under Medicaid must be in accordance with the medical criteria outlined in the most current Guidelines or Standards. Payment must be made for any postpartum home visit or visits for mothers and children within the time periods recommended by attending physicians in accordance with and as indicated by the Guidelines or Standards. Changes in the Guidelines or Standards should be adhered to within 6 months of the publication of revisions or amendments.

The bill also amends § 2.1-20.1 relating to the health coverage of state employees. Health coverage for state employees must include coverage for postpartum services providing inpatient care and a home health visit or visits in accordance with the medical criteria outlined in the most current Guidelines or Standards. The coverage is to incorporate any changes to the Guidelines or Standards within six months of publication or amendment.

Chapter 11(House Bill 299)

This bill amends the Medicare Supplement law (§ 38.2-3600 et seq.) for purposes of conforming Virginia's law to federal requirements. The bill:

- Modifies the types of group policies that may be issued;
- Adds a non duplication of coverage provision; and
- Provides enabling authority for implementation of Medicare Select plans in Virginia.

Chapter 12 (House Bill 300)

This bill amends subsection C of § 38.2-316 to clarify existing Virginia requirements that premium rate changes applicable to individual accident and sickness policies are subject to prior approval.

Chapter 967 (House Bill 442)

This bill adds a new section, § 38.2-3407.10, in the Accident and Sickness Chapter. This bill also amends §§ 38.2-4214 and 38.2-4319 in the Health Services Plans and Health Maintenance Organization Chapters.

The bill provides that insurers, health services plans, and health maintenance organizations issuing individual and group accident and sickness policies and subscription contracts that include coverage for obstetrical or gynecological services, shall permit any female age 13 or older direct access to the health care services of an obstetrician-gynecologist (ob/gyn) (i) authorized under the policy or plan, and (ii) selected by the female without prior approval of the primary care physician (PCP).

The bill also provides that an annual examination and routine health care services incidental to and rendered during an annual visit, may be performed without authorization by the PCP. Additional health care services may be provided, subject to the following:

(i) consultation, which may be by phone, with the PCP for follow-up or subsequent visits;
(ii) prior consultation and authorization by the PCP including a visit to the PCP, if determined necessary by the PCP before a patient is directed to another specialty provider; and
(iii) prior authorization by the insurer, corporation or HMO for proposed inpatient hospitalization or outpatient surgical procedures.

The bill defines "health care services" as meaning the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system and breasts and in performing annual screening and immunization for disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. The term includes services provided by nurse practitioners, physician's assistants, and certified nurse midwives in collaboration with the obstetrician-gynecologists providing care to individuals covered under the policies, contracts or plans.

Insurers, health services plans or health maintenance organizations must inform subscribers of the provisions of this section. This notice must be in writing.

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

The requirements of the new law apply to all policies, contracts and plans delivered, issued for delivery reissued, renewed or extended or at any time when any term of any policy, plan or contract is changed or any premium adjustment is made.

This bill does not prohibit a requirement of written notification of a visit by the ob/gyn to the PCP.

Chapter 262 (House Bill 700)

This bill amends § 38.2-3431 of the small employer group insurance article. The bill expands the definition of a "small employer' governed by the article from "less than 50" to "less than 100."

Chapter 269 (House Bill 835)

This bill amends § 38.2-3232 of the small employer group insurance article. The bill expands the types of prior coverage for which an insurer must provide credit when determining a "pre-existing conditions" limitation. The credit will now include coverage under (i) Medicare, Medicaid, Champus, the Indian Health Service Program, or any other similar publicly sponsored program, (ii) a group health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the "essential" health benefit plan, or (iii) an individual health insurance policy, including coverage issued by a health maintenance organization, health services plan, or fraternal benefit society that provides benefits similar to or exceeding the benefits provided under the "essential" health benefit plan.

Chapter 425(House Bill 897)

This bill is intended to clarify existing law concerning charitable gift annuities by amending § 38.2-106 and adding two new sections designated §§ 38.2-106.1 and 38.2-3113.2.

The amendment to § 38.2-106 states that the term "annuities" does not include "qualified charitable gift annuities." New § 38.2-106.1 defines charitable gift annuities as a class of insurance and also distinguishes "qualified charitable gift annuities." A "qualified charitable gift annuity" is one which satisfies several stated conditions and also conforms to the requirements of specific sections of the Internal Revenue Code (IRS Code).

Provisions of new § 38.2-3113.2 state that the issuance of a qualified charitable gift annuity does NOT constitute either the business of insurance or a violation of the Unfair Trade Practices Act. These provisions also "grandfather' certain qualified charitable gift annuities issued prior to the effective date of the new law, if they conform to the requirements of the specified sections of the IRS Code.

The bill also includes disclosure provisions so that donors are advised that qualified charitable gift annuities are not insurance, and are not protected under the Virginia Life, Accident and Sickness Insurance Guaranty Association Act.

Chapter 550 (House Bill 1026)

This bill amends § 38.2-3514.2 in the Accident and Sickness Insurance Policies Chapter. The bill also amends §§ 38.2-4214 and 38.2-4319 in the Health Services Plans Chapter and the Health Maintenance Organizations Chapter to clarify that the provisions apply to those entities. The bill requires that individual policies and subscription contracts delivered, issued for delivery or renewal in Virginia provide for the renewability of the coverage at the sole option of the insured, policyholder, subscriber, or enrollee. Insurers, health services plans or health maintenance organizations (HMOs) issuing the policy, contract or plan can refuse to renew only for one -of five reasons. The allowable reasons for non-renewal are (i) nonpayment of premium; (ii) a documented pattern of abuse or misuse of a provider network for a period of no less than 2 years; (iii) fraud or material misrepresentation by the individual with respect to his application for coverage, subject to the time limits in § 38.2-3503.2, or in regulations adopted by the Commission governing HMOs; (iv) eligibility for Medicare; or (v) the individual, subscriber or enrollee has not maintained a legal residence in the service area of the insurer, health services plan or HMO for a period of at least 6 months.

The bill does not apply to short-term travel policies, accident-only policies, disability income policies, limited or specified disease contracts, long-term care

insurance and short-term nonrenewable policies or contracts of not more than 6 months duration subject to no medical underwriting or minimal underwriting.

The bill includes a second clause that requires the Joint Commission on Health Care (JCHC), in cooperation with the Commission's Bureau of Insurance, to study additional reforms in the individual market including guaranteed issue requirements and modified community rating for the essential and standard benefit plans. The JCHC is also to evaluate MEWAs and out of state group trusts, and the impact of guaranteed issue requirements on the taxation of open enrollment carriers. The JCHC is to report its findings to the Governor and the 1997 General Assembly by October 1, 1996.

Chapter 628 (House Bill 1130)

The bill adds § 38.2-226.1 to exempt specific long-term care prepaid health plans sponsored by the Department of Medical Assistance Services (the pre-Pace plans) from regulation under Title 38.2 of the Code of Virginia until July 1, 1997. The bill also provides that the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services and the Bureau of insurance, shall conduct a study to (1) determine whether the exemptions established by the bill should be continued in existing or modified form beyond July 1, 1997; and (ii) identify an appropriate state regulatory policy for pre-PACE and PACE projects which may provide coverage for individuals who are not eligible for Medicaid. The Joint Commission on Health Care is to report its findings to the 1997 Session of the Virginia General Assembly.

Chapter 776 (House Bill 1393)

This bill adds § 38.2-3407.10 to the Accident and Sickness Insurance Provisions Chapter. The bill also amends §§ 38.2-4219 and 38.2-4319 in the Health Services Plans and Health Maintenance Organizations Chapters and § 38.2-4509 in the Dental or Optometric Services Plans Chapter.

The bill defines the term "carrier" to mean:

1. any insurer proposing to issue individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;
2. any corporation providing individual or group accident and sickness subscription contracts;
3. any health maintenance organization providing health care plans for health care services;
4. any corporation offering prepaid dental or optometric services plans; or
5. any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

The bill also defines the terms "enrollee," "provider' and "provider panel."

The bill includes requirements for the establishment and use of a provider panel. The requirements include filing a notice of the development of each panel with the Department of Health Professions.

Included in the bill are requirements that procedures be established for notification to providers and notification to purchasers of the health benefit plans.

The notification of purchasers of health benefit plans is to include a description of all types of payment arrangements which the carrier uses to compensate providers, including withholds, bonus payments, capitation. and fee-for-service discounts, and the "practical" application of the terms of the plan.

The bill prohibits denial of an application to participate on a panel or termination of a panel member due to gender, race, age, religion or national origin.

The bill provides that providers may continue to provide services to certain enrollees for 60 days after notice of termination, unless the PCP is terminated for cause. Because of this provision, carriers must reimburse for services provided based on the carrier's agreement with the providers.

Additional provisions require that a new enrollee be given a list of members in its panel and those not accepting new patients.

A contract between a carrier and provider must permit and require the provider to discuss medical treatment options with patients.

The bill prohibits limits on discussion of medical treatment options between a patient and a provider, and also prohibits waivers to rights of legal redress against the carrier by the provider.

Also, contracts shall not require a provider to indemnify a carrier for the carriers negligence, willful misconduct or breach of contract.

A provider must provide reasonable notice to his patients in the event that the provider's contract with the patient's carrier is terminated.

The Commission has no jurisdiction to adjudicate controversies arising out of this bill.

The bill also requires the Joint Commission on Health Care (JCHC), in cooperation with the Bureau of Insurance and the Division of Legislative Services, to study the need to require a point-of-service feature which would allow an enrollee the option to receive health care services outside the provider panel. The study is to include the extent to which provider panels that may not be regulated are forming; the impact of such panels on enrollees; the impact of these panels on access to quality, affordable health care and the need to extend the provisions of § 38.2-3407.10 to such panels. The JCHC must report the findings and recommendations to the Governor and the 1997 General Assembly by December 1, 1996.

The bill applies to all policies, contracts and plans delivered, issued for delivery, reissued or extended on or after July 1, 1996, or any time after the effective date when the terms of the policy, contract or plan are changed or the premium is adjusted. The section applies to contracts between carriers and providers entered into or renewed on or after July 1, 1996.

Chapter 704 (Senate Bill 335)

This bill amends § 38.2-508.4 in the Unfair Trade Practices Chapter and § 38.2613 in the Insurance Information and Privacy Protection Chapter. The bill defines "genetic information" as meaning information about genes, gene products, or inherited characteristics that may derive from the individual or a family member. The bill also defines "genetic test" as meaning a test for determining the presence or absence of genetic characteristics in an individual in order to diagnose a genetic characteristic.

"Genetic characteristic" means any scientifically or medically identifiable gene or chromosome, or alteration thereof, which is known to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder, and which is asymptotic of any disease or disorder.

The bill provides that no person proposing to issue, re-issue, or renew any policy, contract, or plan of accident and sickness insurance defined in § 38.2109, excluding disability income, issued by insurers providing hospital, medical and surgical or major medical coverage on an expense incurred basis, corporations providing a health services plan, or health maintenance organizations (HMOs) providing a health care plan, shall on the basis of genetic information obtained concerning an individual or their request for genetic services, terminate, restrict, limit or otherwise apply conditions to coverage of an individual or restrict the sale to an individual; cancel or refuse to renew coverage, exclude an individual, impose a waiting period prior to "commencement of coverage"; impose a rider that excludes coverage for benefits and services; or establish differences in premiums for coverage.

The bill also prohibits discrimination in the "fees or commissions of an agent or agency" for enrollment, subscription, or renewal of an enrollment or subscription of any person on the basis of a person's genetic characteristics.

The bill provides that all information obtained from genetic screening or testing done prior to the repeal of § 38.2-508.4 is to be confidential.

The information is not to be made public or used in any way in whole or in part, to cancel, refuse to issue or renew, or limit benefits under any policy, contract, or plan subject to the section.

The bill provides in § 38.2-613.B.1. that no person proposing to issue, re-issue, or renew any policy, contract, or plan of accident and sickness insurance defined in § 38.2-109, excluding disability income insurance, shall disclose any genetic information about an individual or a member of such individual's family collected or received in connection with any insurance transaction unless there is written authorization from the individual. Agents and insurance support organizations are subject to the provisions in § 38.2-613.13 to the extent of their participation in the issue, re-issue, or renewal of any policy, contract, or plan of accident and sickness insurance defined in § 38.2-109, excluding disability income insurance. The provisions in the Unfair Trade Practices Act (§ 38.2-508.4) expire on July 1, 1998.

Chapter 610 (Senate Bill 431)

This bill amends § 38.2-3418.1 to change the existing mandated offer of coverage for mammograms to a mandated benefit that must be provided in all individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, including those issued by "Blue" plans and HMOs. The bill also deletes the requirement that such coverage be provided in Medicare Supplement policies.

Chapter 611 (Senate Bill 432)

This bill adds at § 38.2-3418.1:2 and § 38.2-4319 a new mandated benefit applicable to all individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, including those issued by "Blue" plans and HMOs. Each such policy delivered, issued for delivery or renewed in Virginia on or after July 1, 1996 must provide coverage for an annual PAP smear.

Chapter 75 (Senate Bill 437)

This bill amends §§ 38.2-3407.1 and 38.2-4306.1 to require insurers and HMOs, respectively, to pay interest on claims regardless of the amount (current law exempts interest payment if the interest is less than $5). The bill also contains an exemption conforming the requirement for HMOs to the requirement for other carriers. Under this new exemption, interest need not be paid when payment has been or will be made directly to the health care provider pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the HMO's obligation on such claims.

Chapter 41 (Senate Bill 490)

This bill amends § 38.2-3412.1 to revise the current mandate of coverage for mental health and substance abuse services so as to include outpatient services in individual contracts in the same manner as already mandated for group contracts, i.e.:

- a minimum of 20 visits for an adult, child or adolescent each policy or contract year;
- limits on the benefits not to be more restrictive than benefits for physical illness, but the coinsurance factor for the 6th and subsequent visits in a policy/contract year must be at least 50%;
- medication management visits are to be treated the same as for physical illness and are not to count toward the benefit; and
- if all of the expenses for an outpatient visit apply to any policy/contract deductible the visit is not to count toward the benefit maximum.

The bill also makes the section applicable to individual conversion contracts.

PROPERTY AND CASUALTY INSURANCE

Chapter 250 (House Bill 209)

This bill amends §§ 38.2-1904 and 38.2-2005 to allow workers' compensation rates for volunteer firefighters, volunteer lifesaving, and volunteer rescue squad members to be calculated based on the combined experience of both paid and volunteer members. The bill requires the rate to be the same for both the paid and the volunteer members with a minimum premium of $40 per year for any volunteer firefighter or rescue squad member. The Workers' Compensation Code has also been amended under § 65.2-101 to require the premium calculations for volunteer firefighters, volunteer lifesaving, and volunteer rescue squad members to be based on a payroll of $300 per month.

Chapter 966 (House Bill 417)

This bill amends §§ 59.1-435, 59.1-436, 59.1-437 and 59.1-440 by allowing certain third party obligors of extended service contracts to be regulated under that title rather than Title 38.2. The bill requires a third party obligor to prove that it has a net worth of at least $100 million, or that it has liability coverage equal to 100% of its service contract liabilities. The third party obligor's parent company may show proof that it has a net worth of at least $100 million if the parent company agrees to guarantee the obligations of the third party obligor relating to service contracts sold in the Commonwealth.

Chapter 489 (House Bill 524) and Chapter 474 (Senate Bill 554) effective Jan. 1,1997

This bill amends Title 46.2 (Motor Vehicles) by changing DMV`s insurance monitoring system. Insurance companies will have to make a monthly electronic filing to DMV whenever they cancel or provide liability coverage. Insurers having less than 1,000 policies are allowed to report the information manually rather than electronically. Under the new system, if no record of liability insurance is found for a motor vehicle owner, the DMV may require the owner to verify insurance coverage.

Chapter 259(House Bill 611)

The bill amends the definition of "utilization review" has been amended in § 38.2-5300 to exempt property and casualty insurers from the provisions of Chapter 53 (Private Review Agents) and Chapter 54 (Utilization Review Standards and Appeals) of Title 38.2 of the Code of Virginia.

Chapter 232 (House Bill 759)

This bill amends § 38.2-5016 by giving the Board of the Birth-Related Neurological Injury Compensation Program the authority to purchase real estate and personal property, and to place such property in trust for the benefit of claimants.

Chapter 237 (House Bill 975)

This bill amends § 38.2-231 by waiving the cancellation/non-renewal notice requirements for insurers that terminate a commercial liability or commercial automobile policy at the request of the named insured or his duly constituted attorney-in-fact. The bill also amends § 38.2-2114 by waiving the cancellation/non-renewal notice requirements for insurers that terminate a homeowners policy at the request of the named insured's duly constituted attorney-in-fact.

Chapter 239 (House Bill1120) and Chapter 206 (Senate Bill 555)

This bill amends § 38.2-2212 by allowing an insurer to cancel a motor vehicle insurance policy mid-term if the named insured or his duly constituted attorney-in-fact has notified the insurer that he has changed his legal residence from Virginia to another state, and that his vehicle will be garaged in the new state of residence.

Chapter 516 (House Bill 1404)

This bill amends § 8.01-413.01 of the Civil Remedies Code by creating a rebuttable presumption that the bills for medical expense benefits payable under a motor vehicle insurance policy issued pursuant to §§ 38.2-124 and 38.2-2201 are reasonable.

Chapter 276 (House Bill 1405)

This bill amends §§ 38.2-124 and 38.2-2201 by requiring insurers to pay the covered injured person when making payments under medical expense and loss of income benefits. Currently, insurers may make payment to either the injured person or the medical provider.

Chapter 31 (Senate Bill 232)

This bill repeals § 38.2-2228 (medical malpractice claims reports) and § 38.2-2228.* 1 (commercial liability claims reports). Currently, § 38.2-2228 requires all medical malpractice claims opened, settled, adjudicated, or closed without payment to be reported annually to the Commission, and § 38.2-2228.1 requires all commercial liability claims to be reported annually to the Commission.

Chapter 373 (Senate Bill 361)

This bill amends § 38.2-2119 by allowing insurers to offer, as an option, functional replacement cost coverage. Currently, § 38.2-2104 requires insurers to insure property for at least the actual cash value, and to repair or replace property with material of like kind and quality. This bill will permit loss settlement of property with property that serves a functionally equivalent purpose. A disclosure notice must be included with each new policy or original premium notice when coverage is sold on a functional replacement cost basis. Language for the disclosure notice is stated in the bill.

FINANCIAL REGULATION OF INSURANCE

Chapter 47 (House Bill 364)

This bill amends § 38.2-1317 to authorize the Commission to accept. an examination report of a foreign or alien insurer when the Commission determines, in its sole discretion, that the examination was performed in a manner consistent with standards and procedures employed by the Commission in the examination of domestic insurers, and the report is duly authenticated by the insurance supervisory official of the insurer's state of domicile.

Chapter 81(House Bill 430)

This bill amends §§ 38.2-1509 and 38.2-1514 to re-order the priority of liquidation payments in the event of an insolvency. This amendment will give claims of policyholders priority over the payment of tax liens of the United States, and also over the priority given by § 38.2-1514 to the payment of wages to employees of an insurer for services rendered before the commencement of the delinquency proceedings.

Recent court decisions, including the decision by the United States Supreme Court in U.S. Department of the Treasugi vs. Fabe, (113 S.Ct. 2202) have affirmed the right of state insurance laws to afford priority to the claims of policyholders and the costs of administering the liquidation of an insurance company over claims of the United States.

Chapter 77 (House Bill 489)

This bill amends § 38.2-1432 and other provisions throughout the Code of Virginia to substitute the phrase "savings and loan association" for the term 61savings institution."

Chapter 801 (House Bill 1471) and Chapter 831d (Senate Bill 590)

This bill adds § 38.2-1005.1 to identify procedures and matters for the Commission's determination when approving a conversion of a domestic mutual insurer to a domestic stock insurer. The new provisions require that policyholders be given notice and an opportunity to be heard and a determination by the Commission that the plan is fair and equitable to policyholders and subject to approval by a vote that meets statutory prescriptions.

Additional provisions in subsection B (4) require distributions to the State Treasurer. These provisions apply only to a domestic mutual insurer that converted from a health services plan that was in existence prior to December 31,1987.

The new law provides that a plan of conversion that utilizes a statutory merger may be approved under this new section rather than the existing provisions of § 38.2-1018.

Chapter 304 (Senate Bill 225)

This bill adds §§ 38.2-1230 and 38.2-1231 to the Reciprocal Insurance Chapter to require disclosure of certain material transactions when the transaction involves more than 0.5% of the insurer's admitted assets; prior approval if the transaction involves more than 5% of the reciprocal's admitted assets; and an annual filing of and an audited financial report of the attorney-in-fact's financial position.

Affected transactions are "material transactions" between a domestic reciprocal, or an "affiliate" of the reciprocal, and the attorney of the reciprocal or other specified entities, including affiliates of the attorney, other insurers managed by the attorney or an affiliate of the attorney, and persons who act on behalf of or at the direction of the attorney or an affiliate of the attorney.

Other provisions in § 38.2-1230 require that transactions be fair and equitable and accurately disclosed in the books of each party; that fees be reasonable; and expense allocation equitable and accounting in conformity with statutory accounting practices consistently applied. When prior approval is required, failure of the Commission to act within 60 days of notification by the insurer shall constitute approval.

Chapter 32 (Senate Bill 250)

This bill adds § 38.2-1306.1 to authorize the Commission to give confidential treatment to confidential documents and information received from insurance departments of other states. This bill will clearly recognize that confidential information may be provided to other regulators directly or indirectly through officials at the National Association of Insurance Commissioners (NAIC). This new provision will allow the Commission to give to other state regulators the same level of confidential treatment that those regulators are expected to give to documents provided to them by the Commission. (The other provisions contained in this bill are outlined in the Insurance Agents and Continuing Education section of this administrative letter.)

SURPLUS LINES INSURANCE

Chapter 240 (House Bill 1121)

This bill amends g 38.2-4806 to remove the requirement that a surplus lines broker file an affidavit for each policy of insurance procured by the broker which states that such policy was procured in compliance with the Code of Virginia. In addition, the requirement that surplus lines brokers summarize the information in a monthly report is also removed from § 38.2-4806. This bill, which provides for the filing of a combined quarterly affidavit and detailed report covering all insurance policies procured during a particular quarter, will not diminish the amount of information the Commission receives from surplus lines brokers on surplus lines business in Virginia.

TITLE INSURANCE

Chapter 494 (House Bill 613)

This bill adds § 38.2-4610.2 to the Code of Virginia to require a title insurer to evaluate annually the adequacy of its total reserves in a report prepared by a qualified actuary. If statutory reserves held by an insurer are less than those indicated by the report, the company must establish an additional reserve to cover the short-fall.

Chapter 883(House Bill 1229)

This bill amends § 38.2-4614 by adding to the title insurance kickback provision the term "thing of value" which is defined as any payment, advance, funds, loan, service or other consideration. The bill prohibits any kickback, rebate, commission, thing of value or other payment pursuant to any agreement or understanding, oral or otherwise, that business incident to the issuance of any title insurance be referred to any title insurer, title insurance agency or agent. Bona fide advertising and marketing promotions are not considered violations of the kickback provision, nor is providing educational materials or classes to a group of persons or entities pursuant to a bona fide marketing or educational effort. Payment of a bona fide salary or compensation or other payment for services actually performed for the business of the title insurer, title agency or agent is also permitted.

INSURANCE AGENTS AND CONTINUING EDUCATION

Chapter 10 (House Bill 295)

This bill amends §§ 38.2-1831, 38.2-1843, 38.2-1855 and 38.2-1863 in the Insurance Agents Chapter. Each of these code sections lists a number of reasons pursuant to which the Commission may refuse to issue, suspend or revoke the license of an agent, consultant, managing general agent, and reinsurance intermediary, respectively. The amendment to each section will provide clear statutory authority for the Commission to refuse to issue, suspend, or revoke such licenses on the grounds that the agent violated a prior order of the Commission.

Chapter 989 (House Bill 757)- Effective April 17, 1996

This bill adds § 38.2-1812.1 and amends § 38.2-1839 to provide that no agent may provide or offer to provide, directly or indirectly, insurance products to a public body while concurrently on the body's behalf (i) evaluating proposals from other insurance agents; and (ii) recommending the placement of insurance. The bill also provides that no insurance consultant may provide or offer to provide, directly or indirectly, insurance products to a public body while concurrently on the body's behalf (i) evaluating proposals from other insurance agents; and (ii) recommending the placement of insurance.

The bill also adds § 11-44.1 providing that notwithstanding any other provision of law, neither an insurance company authorized in Virginia, nor an approved surplus lines carrier may be excluded from presenting an insurance bid to a public body in response to a request for proposal, or an invitation to bid, unless the insurer or surplus lines carrier has otherwise been debarred.

Chapter 32(Senate Bill 250)

This bill adds § 38.2-234 to provide authority for the Commission to share information with databases developed by the NAIC. This is enabling authority for the Commission to participate in the NAIC's Producer Database and PIN systems, and to utilize agents' social security numbers as identifiers.

Chapter 159 (Senate Bill 506)

This bill amends the Continuing Education (C.E.) law (§ 38.2-1866 et seq.), to make a number of substantive changes:

- Requires that proof of compliance with the C.E. requirements be received by the Continuing Education Board (Board) on or before December 31 of each even-numbered year (except for the 1995-1996 biennium, where agents will continue to have until January 15, 1997).

- Removes the 2 SCC employee members from the Board, and revises the Board's title to clarify that it is no longer an "advisory" board.

- Requires that requests for hardship waivers be made no later than 3 months before the end of the biennium.

- Clarifies that the Board is exempt from the Administrative Process Act.

- Deletes the provision that was applicable only for the first biennium, which has been completed.

- Requires that agents receive a status report from the Board if they have not complied with the C.E. requirement by the 1 eh (starting with the 19971998 biennium) and 23rd month of the biennium; the failure to receive the status report is not a basis for special consideration.

- Clarifies that failure to receive the 30-day warning letter may not be the basis for requesting special consideration.

- Clarifies that the Variable Life and Variable Annuities license, since it is tied to possession of a Life and Health license, will terminate if an agent's Life and Health license terminates for failure to comply with C.E. requirements.

- Permits agents who will lose their licenses because of noncompliance with C.E. requirements to take the study course and examination within 4 months of the date their license will be terminated.

- Does not permit voluntary surrender or moving out-of-state to be used as a means to circumvent the C.E. requirements.

- Clarifies what kinds of situations qualify for waiver of C.E. requirements.
- Removes the requirement that the Commission approve the outside administrator selected by the Board.
- Codifies the date that the Board or its administrator must provide final data to the Commission on an agent's compliance with the C.E. requirements.
- Clarifies that the administrative termination of licenses for noncompliance with C.E. requirements is carried out by operation of law.
- Clarifies that the Board and its administrator will be granted limited access to agent information held by the Commission.
- Clarifies that the Board's legal fees and other legal expenses are to be paid from the fees generated by the C.E. program, and removes the requirement that the Commission approve the way fees are determined.
- Clarifies criteria for creation and amendment of the Board's Plan of Operation, including the appeal process.
- Clarifies that there is no liability on the part of Board members, employees, or the Commission or its representatives because of actions taken or statements made because of good faith performance of duties under the continuing education law.

Chapter 473 (Senate Bill 542)

This bill adds § 38.2-514.1 to require agents to provide a written disclosure to their applicants when they are selling an insurance policy with an automobile club service agreement or with an accidental death and dismemberment policy. The disclosure must give (i) the name or type of each insurance policy and automobile club service agreement the applicant has agreed to purchase; (ii) the premium quotation for each insurance policy and cost of the automobile club service agreement; and (iii) a statement that the applicant has elected to purchase these policies or automobile club service agreement. The disclosure must be signed and dated by the agent and the applicant. This provision does not apply to the sale of group insurance, and only applies to the original issuance of insurance policies and automobile club service agreements covering person, family, or household needs.