Commonwealth of Virginia

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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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Administrative Letter 1997-6

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

RE: **Legislation Enacted by the 1997 Virginia General Assembly**

We have attached for your reference summaries of certain statutes enacted or amended and re-enacted during the 1997 Session of the Virginia General Assembly. **The effective date of these statutes is July 1, 1997, 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 1997 Session. Each organization is responsible for legal review of the statutes pertinent to its operations.

Cordially,

Alfred W. Gross
Commissioner of Insurance

NOTE: EXCEPT WHERE OTHERWISE INDICATED, ALL BILLS ARE EFFECTIVE 7/1/97

PROPERTY AND CASUALTY BILLS

Chapter 26 (Senate Bill 882)

This bill amends § 38.2-317 of the Code of Virginia by giving the State Corporation Commission (SCC) the authority to withdraw approval of a policy form or endorsement previously approved. If the SCC proposes to withdraw approval, it must notify the insurer in writing at least 90 days prior to the proposed effective date of withdrawal and must give its reasons for withdrawal. The bill also gives the SCC the authority to extend for an additional 30 days the period within which it may approve or disapprove a policy form or endorsement. The bill further states that if, at the end of the 30 days, the period has not been extended, or at the expiration of the extended period, a policy form or endorsement has not been approved or disapproved by the SCC, it shall be deemed approved if written notice of the intent to use the policy form or endorsement has been filed with the SCC. Such notice may be filed at the end of the 30 days if the period has not been extended or at the expiration of the extended period.

Chapter 30 (Senate Bill 1071)

This bill amends § 59.1-436 in Title 59.1 (Trade and Commerce) by removing from the regulatory jurisdiction of the Bureau of Insurance the providers of extended service contracts sold on motor vehicles. Providers of motor vehicle extended service contracts, including third party obligors, will now be regulated by the Department of Agriculture and Consumer Services under Title 59.1, along with providers of other extended service contracts.

Chapter 153 (House Bill 2244)

This bill amends §§ 38.2-1901 and 38.2-1903 by allowing retrospective rating plans for large risks to be exempt from the rate filing requirements of Chapter 19 (Regulation of Rates Generally) of Title 38.2. Large risks are defined as those which generate total estimated standard premium for workers' compensation of at least $500,000 annually (or less or in combination with other lines if approved by the SCC). Copies of large risk rating plans must be made available to the SCC upon request, and insurers' experience attributable to large risks must be filed with the SCC in accordance with § 38.2-1919.

Chapter 157 (House Bill 2276)

This bill adds a new section § 38.2-235, to prohibit liability insurance policies from excluding coverage for the discharge, dispersal, seepage, migration, release, emission, leakage, or escape of carbon monoxide from a residential or commercial heating system unless the policy explicitly makes reference to the exclusion.

Chapter 170 (Senate Bill 959)

This bill is very similar to House Bill 2501. It amends the definition of "uninsured motor vehicle" in § 38.2-2206. Under the amended definition, a vehicle is uninsured if the owner or operator is immune from liability for negligence under the laws of the Commonwealth or the United States. The bill also states that immunity from liability for negligence of the owner or operator of a motor vehicle shall not be a bar to the insured obtaining a judgment enforceable against the insurer and shall not be a defense available to the insurer to the action brought by the insured.

Chapter 191 (House Bill 2501)

This bill amends the definition of "uninsured motor vehicle" in § 38.2-2206. Under the amended definition, a vehicle is uninsured if the owner or operator is immune from liability for negligence under the laws of the Commonwealth or the United States. The bill also states that immunity from liability for negligence of the owner or operator of a motor vehicle shall not be a bar to the insured obtaining a judgment enforceable against the insurer for the negligence of the immune owner or operator and shall not be a defense available to the insurer to the action brought by the insured.

Chapter 199 (Senate Bill 1065)

This bill repeals §§ 38.2-1905.1 and 38.2-1905.2. **Insurers will no longer be required to file their supplemental reports previously due on May 1.** Sections 38.2-1905.1 and 38.2-1905.2 required the SCC to file a biennial report with the General Assembly naming the lines of commercial liability insurance found to be potentially non-competitive; required insurers to file supplemental report information for the lines designated as potentially non-competitive; and required the SCC to hold a hearing biennially to determine which lines should be subject to delayed-effect rate regulation. Amendments to § 38.2-1906 (filing and use of rates) have been made for consistency.

Chapter 377 (House Bill 1997)

This bill amends § 38.2-2226 by requiring an insurer to give the claimant or the claimant's counsel notice of an insured's breach of the insurance contract regardless of whether the insurer intends to rely on the breach as a defense. This notice must be given within 45 days from the date the breach was discovered or from the date of the claim, whichever is later. Furthermore, whenever a nonwaiver of rights agreement is executed or whenever the insurer sends an insured a reservation of rights letter, notification must also be given to the claimant or the claimant's counsel. This must be given within 45 days after the agreement is executed or the letter is sent or after notice of the claim is received, whichever is later. Failure to give 45 days' notice will result in the insurer not being allowed to use the breach of contract as a defense.

Chapter 399 (House Bill 2384)

This bill amends § 38.2-5016 by requiring the Board of Directors (Board) of the Birth-Related Neurological Injury Compensation Fund (Fund) to discharge its duties solely in the interest of the recipients of awards pursuant to § 38.2-5009 and to seek the advice of an investment advisor whenever decisions are made regarding the investment of the Fund's assets. The Board is also required to report its investments annually to the Speaker of the House and the Chairman of the Senate Rules Committee.

Chapter 401 (House Bill 2418)

This bill amends § 8.01-66.1 (Civil Remedies) pertaining to the bad faith refusal of an insurer to pay a motor vehicle claim. An insurer who in bad faith refuses to pay its insured's claim of $2,500 or less in excess of the deductible must pay double the amount otherwise due and payable plus attorney's fees and expenses. An insurer who in bad faith refuses to pay a third party's claim of $2,500 or less must pay double the amount of the judgment awarded to the claimant plus attorney's fees and expenses. An insurer who in bad faith refuses to pay its insured's claim of more than $2,500 in excess of the deductible must pay the insured the amount otherwise due and payable plus interest on the amount due at double the rate of interest provided in § 6.1-330.53 from the date the claim was submitted, plus attorney's fees and expenses.

Chapter 410 (House Bill 2673)

This bill adds a new section § 65.2-813.2 to the Workers' Compensation Act, requiring insurers to give a premium discount of up to 5% to employers that institute a drug-free workplace program. The program must satisfy the insurer's underwriting criteria in order to qualify for the discount. The discount is limited to four years. In order to

comply with this provision of the Workers' Compensation Act, **all insurers writing workers' compensation insurance in Virginia must file their drug-free workplace premium credit and eligibility criteria with the Bureau of Insurance on or before July 1, 1997.**

Chapter 503 (House Bill 2541)

This bill amends § 8.01-413.01 (Civil Remedies) and § 38.2-2201 of Title 38.2. The bill states that an expense is deemed to have been incurred (a) if the insured is directly responsible for payment of the expense; (b) if the expense is paid by (i) a health care insurer pursuant to a negotiated contract with the health care provider; or (ii) Medicaid or Medicare, where the actual payment with reference to the medical bill rendered by the provider is less than or equal to the provider's usual and customary fee, in the amount of the actual payment; however, if the insured is required to make a payment in addition to the actual payment by the health care insurer or Medicaid or Medicare, the amount shall be increased by the payment made by the insured; (c) if no medical bill is rendered or specific charge made by a health care provider to the insured, an insurer, or any other person, in the amount of the usual and customary fee charged in that community for the service rendered.

TITLE BILLS

Chapter 426 (House Bill 2892)

This bill amends § 38.2-4601.1 by requiring that title insurance agents holding any funds in escrow must promptly deposit those funds in a trust account in a financial institution licensed in Virginia. The trust account must be kept separate from all other accounts held by the title agent.

Chapter 716 (Senate Bill 1104)

This bill adds Chapter 1.3 to Title 6.1 (Banking and Finance) requiring settlement agents to register with the Virginia State Bar within 90 days of the effective date of the Consumer Real Estate Settlement Protection Act. The Bureau of Insurance will be responsible for regulating the activities of settlement agents who are title insurance agents or title insurance companies. The Virginia State Bar will oversee the activities of settlement agents who are attorneys, and the Virginia Real Estate Board will regulate settlement agents who are real estate brokers. Settlement agents other than title insurance companies and financial institutions will be required to maintain an errors

and omissions or malpractice policy providing a minimum of $250,000; a blanket fidelity bond or employee dishonesty policy providing a minimum of $100,000 which may be waived when there are no employees; and a surety bond of not less than $100,000. Settlement agents who are not attorneys will be required to have an annual audit of their escrow accounts. A disclosure will be required to be given in real estate contracts involving the purchase of four or fewer residential dwelling units. The disclosure must advise the purchaser that he has a choice of settlement agents; that settlement agents may not give legal advice if they are not attorneys in the private practice of law in Virginia representing a party to the transaction; and that guidelines issued by the Virginia State Bar are available to the purchaser regarding the unauthorized practice of law. The bill also sets forth conditions for providing escrow services and maintaining escrow accounts, and it requires settlement agents to maintain their records for five years.

INSURANCE AGENTS AND CONTINUING EDUCATION BILLS

Chapter 513 (House Bill 2817)

This bill amends § 38.2-1816 in the Agents Chapter of Title 38.2. The bill provides that the 45-hour prelicensing study course for a property and casualty or life and health agent's license, and the 25-hour prelicensing study course for a health agent's license, may be completed by classroom instruction or distance learning or any combination thereof. The bill defines "distance learning" as meaning instruction delivered under the general supervision of an instructor through a medium other than a classroom setting. The bill also defines "classroom instruction" as meaning actual hours in a classroom environment with an instructor. The bill authorizes instructors to consider the requirement met if the applicant is present for no less than 95% of the required hours.

NOTE: It is the Bureau's interpretation that the term "distance learning" is NOT synonymous with the term "self-study." Distance learning requires supervision of an instructor, although the instructor may not be physically present. Distance learning provides a means for those who are geographically removed from convenient access to classroom instruction to participate via video conference, CD-ROM, Internet or other means. Those providing prelicensing education are urged not to interpret this term too broadly.

Chapter 583 (Senate Bill 1082)

This bill amends §§ 38.2-1816, 38.2-1818, 38.2-1822, 38.2-1825, 38.2-1838, 38.2-1841, 38.2-1869 and 38.2-1871 in the Agents Chapter of Title 38.2. The bill also enacts § 38.2-1800.1.

A new § 38.2-1800.1 defines more specifically the residency requirements for the purpose of licensing agents and consultants. Such specific requirements will help prevent abuses by non-residents who falsely obtain or retain a Virginia resident license.

Amendments to § 38.2-1816 define the terms "classroom instruction and distance learning" when used to describe the agents' prelicensing study course, and provide sanctions against instructors and applicants who submit materially false certifications regarding completion of course work.

An amendment to § 38.2-1818 provides for a 60-day grace period for nonresident agents moving to Virginia while they are in the process of becoming Virginia licensed agents.

An amendment to § 38.2-1822 adds appropriate references to limited liability companies, in addition to current references to limited partnerships and corporations, and makes statutory language consistent for limited liability companies.

Sections 38.2-1825 A 2 and 38.2-1841 B are amended to allow a period of 90 days to lapse before terminating an insurance agency license or an insurance consultant license for a corporation or limited liability company that has had its charter or certificate of authority revoked by the Clerk of the SCC. This grace period would allow a corporation or limited liability company sufficient time to have its charter or articles of incorporation reinstated without losing its licenses to do business as an insurance agency.

An amendment to § 38.2-1838 and a new subsection E in § 38.2-1869 modify the continuing education requirements for those holding insurance consultant licenses.

An amendment to § 38.2-1841 makes the due date for the renewal fee consistent with the present expiration date of the license for an insurance consultant.

An amendment to § 38.2-1871 B 3 clarifies that any agent seeking a permanent exemption from continuing education requirements must file a request to be granted such an exemption in the form and manner required by the Continuing Education Board. Such a permanent exemption is currently available to agents having reached the age of 65 and having been continuously licensed for at least 20 years; however, agents must submit a request for such an exemption.

LIFE AND HEALTH BILLS

Chapter 28 (Senate Bill 955)

The bill amends § 38.2-109 in the General Provisions Chapter of Title 38.2 by adding a subsection B. The bill expands the definition of "accident and sickness insurance" to include agreements insuring against losses resulting from health care claims or expenses in excess of a specific or aggregate dollar amount when such agreements are used to provide coverage to (i) an employee welfare benefit plan or any other plan providing accident and sickness benefits; (ii) health maintenance organizations (HMOs); or (iii) providers associated with a managed care network. Additional requirements for agreements to be included in the definition are that (i) the agreement clearly indicates the liability assumed by the insurer; and (ii) the insurer maintains reserves according to § 38.2-1314 for liability under the agreement.

The agreements are not subject to the requirements of Chapters 34 and 35 of Title 38.2.

Chapter 56 (Senate Bill 919)

This bill amends § 38.2-3407.3 in the Accident and Sickness Insurance Provisions Chapter. The bill revises the calculation of cost-sharing provisions section. The amended subsection A requires insurers to calculate copayments payable by insureds "based upon an amount not to exceed the total amount actually paid or payable to the provider of such services provided to the insured, subscriber or enrollee."

Chapter 139 (House Bill 2062)

This bill amends the Health Maintenance Organizations (HMO) Chapter of Title 38.2 by adding a § 38.2-4312.3. The new section requires each HMO to have a system that provides on a 24-hour basis (i) access to medical care; or (ii) access by telephone to a physician or licensed health care professional that can refer a member for prompt medical care where there is an immediate, urgent need or medical emergency.

Access to a non-medical professional who responds to calls from members and providers regarding after-hours care and covered benefits is not considered sufficient to meet the above requirement.

The bill requires an HMO to reimburse a hospital emergency facility and provider for "medical screening and stabilization services" rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395 dd) and

related to the condition that the member presented in the facility if one of two conditions is met. The first condition is that the HMO, or its designee, or the member's primary care physician (PCP) or its designee, authorized, directed or referred a member to use the hospital emergency facility. The alternate condition is that the HMO fails to have a system for provision of 24-hour access according to the requirements in subsection A of this bill. A PCP may include a physician providing on call back-up coverage for the PCP.

The bill also requires HMOs to include in each evidence of coverage a description of procedures to be followed for emergency services. The required description must address (i) appropriate use of hospital emergency facilities; (ii) appropriate use of urgent care facilities that the HMO has contracted with; (iii) the potential responsibility of the member for payment of non-emergency services rendered in a hospital emergency facility; and (iv) covered benefits including an explanation of the prudent layperson standard pursuant to the definition of emergency services in § 38.2-4300.

Chapter 203 (House Bill 1360)

This bill amends §§ 38.2-3408 and 38.2-4221 in the Accident and Sickness Provisions and the Health Services Plans chapters of Title 38.2 by adding "certified nurse midwife" to the list of providers that are mandated to receive direct reimbursement.

Chapter 290 (House Bill 2647)

This bill adds § 38.2-613.01 to the Insurance Information and Privacy Protection Chapter of Title 38.2. The bill provides that pursuant to §§ 38.2-223 and 38.2-3100.1, the SCC shall promulgate regulations necessary to ensure that applicants for life or accident and sickness coverage or changes to existing coverage are notified of HIV test results.

NOTE: The Bureau of Insurance believes that the Commission's existing "Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome" (14 VAC 5-180 et seq.) already address this requirement.

Chapter 291 (House Bill 2747)

This bill amends § 38.2-3514.1 in the Individual Accident and Sickness Policies Chapter of Title 38.2. The bill adds disability income policies to the types of contracts that are not subject to the 12-month preexisting conditions limit and the requirement that policies provide a credit towards the preexisting conditions period for the time that the person was covered under previous individual or group coverage.

Chapter 297 (House Bill 2870)

This bill expands § 38.2-4312 to prohibit an HMO from referring an enrollee who is a resident of a continuing care facility to nursing home outside the continuing care facility unless the primary care physician determines that it is in the best interests of the patient.

A second clause prohibits referrals outside the continuing care facility if the facility's nursing home agrees to accept reimbursement at the rate applicable to such coverage under the enrollee's plan.

Chapter 415 (House Bill 2786)

This bill amends § 9-298 (Commissions, Boards and Institutions), relating to the duties of the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). The Advisory Commission is given the responsibility to review and evaluate the benefits and other provisions of the Essential and Standard health benefit plans established pursuant to § 38.2-3431 in the Small Employer Market Provisions article of Title 38.2. The Advisory Commission shall submit its recommendations for any modifications needed to maintain or enhance the affordability and marketability of the Essential and Standard plans to the SCC for adoption by regulation.

The bill also adds Medicaid coverage to the list of coverages not included in the term "health benefit plan." Individuals who have premium payments made by Medicaid are added to the list of those exempt from late enrollee exclusions.

The bill also requires that all Essential and Standard plans delivered, issued for delivery, reissued, renewed or extended in Virginia on or after July 1, 1997 must include coverage for 365 days of inpatient hospitalization in a 12-month period. If coverage under the Essential or Standard plan terminates while the person is hospitalized, the benefits must continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided; or (ii) the day the covered person is no longer hospitalized.

NOTE: The provision noted above requiring 365 days of coverage of inpatient hospitalization in a 12-month period, which becomes effective July 1, 1997, will supersede the relevant provisions of the SCC's Rules Governing Essential and Standard Health Benefit Plan Contracts (14 VAC 5-234-10 et seq.) regarding inpatient hospitalization which are found at 14 VAC 5-234-50 (1) for Essential plans and 14 VAC 5-234-60 (1) for Standard plans. These rules will be revised after the Advisory Commission has developed its recommendations for the Essential and Standard plans.

Chapter 531 (Senate Bill 1123)

This bill amends § 38.2-322 by adding a new subsection E. It prohibits carriers from requiring providers to utilize CPT codes and appropriate modifiers in submitting claims unless the carriers are capable of accepting and utilizing those codes and modifiers in processing the claims.

Chapter 656 (Senate Bill 1164)

This bill amends § 2.1-20.1 (Health) relating to health coverage for state employees (**not relevant**) and also § 38.2-3407.5 in the Accident and Sickness Provisions Chapter of Title 38.2.

The bill prohibits the denial of coverage for any drug prescribed to treat a covered indication as long as the drug has been approved by the U.S. Food and Drug Administration (FDA) for at least one indication, and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or substantially accepted peer-reviewed medical literature. This provision also applies to hospital, medical and surgical or major medical coverage on an expense incurred basis, subscription contracts and HMO health care plans that include coverage for prescription drugs.

The bill revises current subsection C in § 38.2-3407.5 to provide that companies are not required to cover indications for which a drug has been determined by the FDA to be contraindicated.

The bill defines the terms "peer-reviewed medical literature" and "standard reference compendia." The bill applies to contracts, policies or plans delivered, issued for delivery or renewed in the Commonwealth on and after July 1, 1997.

Chapter 688 (House Bill 2785)

This bill adds § 32.1-122.10:01 (Health) and revises §§ 38.2-305, 38.2-4214, 38.2-4308, 38.2-4315 and 38.2-4319 of Title 38.2.

The bill provides that the Commonwealth's Health Commissioner shall examine the quality of health care services of any health maintenance organization (HMO) licensed in Virginia and the providers with which the HMOs contract or have agreements or arrangements. The Health Commissioner may examine an HMO as often as necessary. The examination may include a review of records, the taking of affidavits, and the interview of officers and agents of the HMO and principals of the providers.

The expenses of the examination are to assessed against the HMO. The Health Commissioner is to consult with HMOs and providers in carrying out these responsibilities.

The bill allows the Health Commissioner to consider the report of an insurance official, regulatory agency, accrediting organization or health commissioner of another state for a foreign HMO. The Health Commissioner is to (i) consult with HMOs in the establishment of their complaint systems; (ii) analyze HMO complaint records; and (iii) assist the SCC in examining the complaint systems. The Health Commissioner is to coordinate the activities under § 32.1-122.10:01 with the SCC to ensure appropriate oversight and to avoid undue duplication of effort or regulation.

Section 38.2-305 is revised to include new or renewal certificates or evidences of coverage to enrollees in the requirement of a notice regarding contacting the Bureau of Insurance regarding complaints.

NOTE: The above referenced notice to accompany an insurance policy, which is required pursuant to § 38.2-305, is not considered part of the policy or contract. Therefore, such notices do not need to be filed for approval with the Bureau of Insurance. This Bureau of Insurance policy regarding notices that accompany policies was established pursuant to Administrative Letter 1988-10, which, as clarified in Administrative Letter 1988-11, did not at that time apply to health maintenance organizations (HMOs) or health services plans (HSPs). The amendments to § 38.2-305 specify that the requirements regarding notices to accompany policies will henceforth apply to HMOs and HSPs, and the Bureau of Insurance will monitor compliance with these requirements through market conduct examinations and consumer complaint reviews.

So that all companies have standard guidelines, the following address and telephone numbers for the Bureau of Insurance should be used, depending on the type of policy or contract issued:

Life and Health Division Bureau of Insurance P.O. Box 1157 Richmond, Virginia 23218 Telephone: (804) 371-9691 Fax: (804) 371-9944	Property and Casualty Division Bureau of Insurance P. O. Box 1157 Richmond, Virginia 23218 Telephone: (804) 371-9185 Fax: (804)371-9396

Toll-free calls: 1-800-552-7945 (in-state only)

Section 38.2-4308 is revised to clarify that the SCC, in cooperation with the Health Commissioner, shall examine HMO complaint systems. The section also provides that the SCC may accept the report of the examination of the Health Commissioner instead

of making its own examination. Section 38.2-4315 is revised to delete current subsections B, C and D, and to add language requiring the SCC to coordinate its exams with the Health Commissioner to ensure an appropriate level of regulatory oversight and avoid undue duplication of effort and regulation.

Additional enactment clauses require the Health Commissioner in cooperation with the Bureau of Insurance, the Department of Health Professions, and other state agencies to study quality of care mechanisms in place for HMOs and providers. The study is to assess the sufficiency of the quality of care mechanisms and whether these mechanisms should be expanded to other entities; and also to examine how the Department of Health and the Bureau of Insurance can coordinate their roles. Changes to existing laws or regulations regarding complaints and the need for a mechanism to adjudicate controversies will also be considered as part of the study.

The Health Commissioner is requested to submit a report to the Governor and Joint Commission on Health Care (JCHC) by October 1, 1997. The report is to (i) recommend the appropriate role of the Commonwealth in monitoring and improving the quality in managed care plans which require or create incentives for covered persons to use health care providers employed by or under contract to the health carrier; (ii) address the Commonwealth's role in providing consumer information on managed care issues; (iii) assess the current licensing functions for individuals and institutional health care providers and whether modifications or consolidation would enhance Virginia's efforts in overseeing quality of managed care plans; and (iv) evaluate the need to establish an external appeals or ombudsman process for resolving consumer complaints and determine which entity should administer the process.

The Department of Health is also to receive and respond to complaints from enrollees in managed health care plans regarding quality of care issues, and the Bureau of Insurance is to forward to the Department the complaints it receives from entities under its consumer complaint program.

Chapter 748 (House Bill 1233)

This bill adds § 38.2-3407.5:1 to the Accident and Sickness Provisions Chapter of Title 38.2. The bill requires that insurers proposing to issue individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis; corporations providing individual or group accident and sickness subscription contracts; and Health Maintenance Organizations (HMO) providing a health care plan for health care services, and whose policy, contract or plan covers outpatient prescription drugs, shall *offer and make available* coverage for any prescribed drug or device approved by the U.S. Food and Drug Administration (FDA) for use as a contraceptive.

The bill provides that no insurer, corporation or HMO shall impose upon any person receiving prescription contraceptive benefits pursuant to this section any (i) copayment or fee that is not equally imposed upon all individuals in the same benefit category, class or copayment level receiving benefits for prescription drugs; or (ii) reduction in allowable reimbursement for prescription drug benefits.

The bill provides that the language is not to be construed to (i) require coverage for prescription drugs in any contract, policy or plan that does not provide prescription coverage; (ii) preclude the use of closed formularies, provided that such formularies include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods; or (iii) require coverage for experimental contraceptive drugs not approved by the FDA. The bill does not apply to short-term travel, accident-only or short-term nonrenewable policies covering six months or less.

The bill becomes effective for contracts, policies, or plans delivered or issued for delivery or renewal in Virginia on or after July 1, 1997.

Chapter 814 (House Bill 871)

This bill amends Title 38.2 to add a new Chapter 57 (§§ 38.2-5700 through 38.2-5707) relating to Viatical Settlements of Title 38.2. The bill authorizes the SCC to require any person engaging in the business of viatical settlement brokering or acting as a viatical settlement provider to be licensed by the SCC and to pay a licensing fee.

The bill defines “viatical settlement” as meaning compensation or other valuable consideration paid to the viator in return for the viator’s assignment, transfer, sale, devise or bequest of the death benefit or ownership of a life insurance policy or certificate to the viatical settlement provider which compensation or other valuable consideration is less than the expected death benefit of the life insurance policy or certificate.

The bill also defines the terms "viatical settlement broker,” "viatical settlement contract," "viatical settlement provider," “viaticated policy” and “viator.”

The bill allows the SCC, on and after January 1, 1998, to require the licensing of viatical settlement brokers and viatical settlement providers, and to require the payment of a nonrefundable application fee.

The bill authorizes the SCC to require the renewal of these licenses, and to determine the frequency of such renewal requirements and the payment of renewal fees. The SCC is also authorized to investigate applicants, as it may deem appropriate, in order to determine whether a license should be issued.

The bill sets forth the circumstances in which the SCC may suspend, revoke, or refuse to issue a new license. The SCC shall also require that viatical settlement providers be bonded.

SCC approval is required for viatical settlement contract forms used on and after January 1, 1998.

The SCC shall have the right to examine and investigate the business affairs of any licensed viatical settlement provider or broker, or applicant for a viatical settlement provider or broker license, engaged or alleged to be engaged in the business of viatical settlements.

The bill also sets forth disclosure requirements of viatical settlement providers, informed consent, and unconditional refund provisions.

The SCC may:

1. Establish standards for evaluating reasonableness of payments under viatical settlement contracts. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise or bequest of a benefit under a life insurance policy; and

2. Set the amount of any bond required for viatical settlement providers.

The bill prohibits licensed insurers from "transacting the business of a viatical settlement provider."

Chapters 807 and 913 (Senate Bill 1112 and House Bill 2887)

These companion bills amend §§ 38.2-3431, 38.2-3433 38.2-4214, 38.2-4216.1, 38.2-4217, 38.2-4229.1, 38.2-4306, 38.2-4319 and 58.1-2501 and add §§ 38.2-3430.1 through 38.2-3430.10, 38.2-3432.1 through 38.2-3432.3, 38.2-3434 through 38.2-3437, 38.2-4322 and 38.2-4323. The bills also repeal § 38.2-3432. The bills contain the provisions necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) recently passed by Congress.

The bills include requirements in the individual health insurance market that eligible individuals have guaranteed availability. All eligible individuals, as defined in the bills, must be provided a choice of all the individual coverage being offered by a health insurance issuer. The term "health insurance issuer" is also defined in the bills. The bills prohibit the use of a conditions exclusion for the eligible individuals as well as the exclusion or limitation of named conditions.

Requirements for guaranteed renewability are also included as well as requirements for the issuance of certifications.

Section 38.2-3430.9 provides that the SCC may adopt regulations to establish and administer standards of the chapter that are necessary to implement the article and assure that Virginia's regulation of health insurance issuers is not preempted by HIPAA. The bills also allow the Commission to revise or amend the regulations and increase the scope of the regulations to maintain federal approval.

The new article will define the following terms: "affiliation period," "beneficiary," "bona fide association," "certification," "church plan," "COBRA continuation provision," "creditable coverage," "eligible individual," "employee," "employer," "enrollment date," "excepted benefits," "federal government," "governmental plan," "group health insurance coverage," "group health plan," "health insurance coverage," "health insurance issuer," "health maintenance organization," "health status-related factor," "individual health insurance coverage," "individual market," "large employer," "large group market," "medical care," "network plan," "nonfederal governmental plan," "participant," "placed for adoption," "plan sponsor," "preexisting condition exclusion," "small employer," "small group market," "state" and "waiting period."

The new statute also requires guaranteed renewability and the offer of all contracts sold in the small group markets to all small groups. Group coverage must be offered and made available to all of the eligible employees of a small employer and their dependents. No coverage can be offered to only certain employees and their dependents, and no employees or their dependents can be excluded or charged additional premiums because of health status.

Preexisting conditions periods are limited to 12 months (18 months for a late enrollee) with a 6-month look-back provision. The preexisting conditions period must be reduced by the aggregate periods of creditable coverage. No preexisting exclusions can be applied for pregnancy; in addition, no preexisting exclusions can be applied for newborns or adopted children covered within 30 days.

Requirements are included for certification of coverage.

The Essential and Standard plans must be subject to modified community rating when sold in the small group market. Rating factors for claim experience, health status and duration of coverage may deviate only plus or minus 20% from the community rate.

Requirements are included for disclosure of information to employers and eligibility to enroll. The new statute does not apply to (i) groups with less than two participants who are current employees on the first day of the plan year; (ii) any nonfederal governmental plan that elects not to be bound by the requirement; or (iii) any group health plan and health insurance issuer for excepted benefits.

The bills also amend §§ 38.2-4214, 38.2-4216.1, 38.2-4217, and 38.2-4229.1 in the Health Services Plans Chapter of Title 38.2 to revise the definition of open enrollment contracts to delete groups with less than 50 members. The tax rate for small group contracts is also revised in the chapter to 2.25%. Section 58.1-2501 is also revised to include the 2.25% tax rate for small group and .75% for individual contracts.

Sections 38.2-4306 and 38.2-4319 are revised to make the provisions in Chapter 34 (Provisions Relating to Accident and Sickness Insurance) of Title 38.2 apply to HMOs. Sections 38.2-4322 and 38.2-4323 are added to include provisions for affiliation periods and alternative methods to affiliation periods.

A second enactment clause requires the Bureau of Insurance to monitor the impact of the bill on health insurance in Virginia. The Joint Commission on Health Care is to cooperate with the Bureau of Insurance. Any revisions, corrections or improvements that require additional legislation are to be recommended by the Bureau of Insurance to the Governor and the 1988 Virginia General Assembly.

FINANCIAL REGULATION BILLS

Chapter 160 (House Bill 2327)

This bill amends provisions in §§ 38.2-1611.1, 38.2-1709 and 38.2-2806 pertaining to the availability and use of tax credits for assessments paid by an insurer to the Virginia Property and Casualty Insurance Guaranty Association; the Virginia Life, Accident and Sickness Insurance Guaranty Association; and the medical malpractice joint underwriting association established pursuant to the provisions of Chapter 28 (Medical Malpractice Joint Underwriting Association) of Title 38.2.

Sections 38.2-1611.1 and 38.2-1709 are amended to allow insurers to amortize contributions made to an association after January 1, 1998 in equal amounts over the 10 years following payment. An insurer with an unamortized contribution outstanding on January 1, 1998 has the option of continuing with the original amortization schedule or amortizing the remainder in equal amounts over a 10-year period beginning January 1, 1998. The insurer must notify the SCC of the desired option on or before March 1, 1998. Insurers failing to so notify the SCC shall be deemed to have selected to continue amortization under the original schedule.

No phase-in is necessary for the credits recognized following payment of medical malpractice joint assessments by members of the association. The amendment to § 38.2-2806 provides that the amount of premium tax deduction for each member's

share shall be apportioned by the SCC so that the amount of each member's premium tax deduction in each of the 10 calendar years following payment of the member's assessment is equal to 10% of the assessment paid by the member.

Chapter 414 (House Bill 2784 and Senate Bill 1102)

This bill amends § 38.2-226.1 and enacts § 32.1-330.3 (Health) to address the operation of pre-PACE plans and to establish more clearly the regulatory oversight of such plans by the Department of Medical Assistance Services (DMAS). PACE is an acronym for the Program of All-Inclusive Care for the Elderly (PACE). Legislation enacted in 1996 exempted such plans from regulation by the Bureau of Insurance if a signed agreement with DMAS existed.

The new provisions in Title 32.1 use language from Title 38.2 to provide a clear definition for pre-PACE plans; to address certain contract requirements; and to establish essential solvency requirements.

Subsection E of § 32.1-330.3 establishes special solvency and disclosure requirements for plans with "private pay individuals."

Subsection G of § 32.1-330.3 establishes a Transitional Advisory Group to determine license requirements, regulations and ongoing oversight. The Transitional Advisory Group is to include representatives from seven state agencies, including DMAS and the Bureau of Insurance, and a pre-PACE provider.

Chapter 615 (House Bill 2335)

The bill enacts a new Chapter 30 in Title 55 (Property and Conveyances) to require all non-profit entities to give written notice to the Attorney General prior to disposing of assets so that the Attorney General may exercise his common law and statutory authority over the activities of these organizations.

The term "non-profit entity" is defined as certain hospitals licensed under the provisions of Title 32.1 (Health) or Title 37.1 (Mental Health); any health services plans licensed under Chapter 42 (Health Services Plans) of Title 38.2; and any health maintenance organization licensed under Chapter 43 (Health Maintenance Organizations) of Title 38.2 which is exempt from taxation under U.S.C. § 501(c)(3).

The term "disposition of assets" is defined as any action undertaken by a nonprofit entity to dispose of control of all or substantially all of its assets pursuant to an agreement of sale, transfer, lease, exchange, option, joint venture or partnership or to restructure the nonprofit entity of its assets which results in a change in control or governance of the entity or assets.

The written notice to the Attorney General must be given on a form provided by the Attorney General 60 days in advance of the effective date of such proposed transaction. The bill also provides that the Attorney General may employ expert assistance in reviewing the proposed transaction at the expense of the regulated party of the transaction.

This bill applies to any disposition of assets to take effect on or after July 1, 1997.

Chapter 917 (Senate Bill 923)

This bill amends § 2.1-563.31 (Administration) and enacts a new Chapter 39 of Title 59.1 (Trade and Commerce) to allow state agencies to recognize and accept digital signatures provided that such digital signatures meet the standards established by the Council on Information Management (Article 7, Chapter 35.1, Title 2.1).

The term “digital signature” is defined in § 59.1-467 as an electronic identifier created by computer which is intended by the party to have the same force and effect as the use of a manual signature.

The Council on Information Management shall adopt regulations on the use of digital signatures on or before September 1, 1998.

Nothing contained in this bill requires any public entity to use or accept digital signatures.