BUREAU OF INSURANCE

June 30, 1998

Administrative Letter 1998-5

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

RE: **Legislation Enacted by the 1998 Virginia General Assembly**

We have attached for your reference Bureau staff summaries of certain statutes enacted or amended and re-enacted during the 1998 Session of the Virginia General Assembly. **The effective date of these statutes is July 1, 1998, 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 1998 Session. Each organization is responsible for legal review of the statutes pertinent to its operations.

Cordially,

Alfred W. Gross
Commissioner of Insurance

AWG/dpb

Attachment

NOTE: EXCEPT WHERE OTHERWISE INDICATED, ALL BILLS ARE EFFECTIVE 7/1/98

COMPANY TAXATION BILLS

Chapter 15 (Senate Bill 40)

This bill amends **§ 38.2-407** (Assessment for Administration of Insurance Laws) so that any insurer subject to paying the maintenance assessment of the Bureau of Insurance pursuant to § 38.2-400 shall file a quarterly declaration of estimated assessment report for the assessable year as provided in Chapter 4 of Title 38.2 if the assessment imposed by § 38.2-400 can reasonably be expected to exceed $3,000.

Chapter 60 (Senate Bill 247)

This bill amends **§ 38.2-1026** (Organization, Admission and Licensing of Insurers) relating to retaliatory tax payments and reports. This bill adds language to specify the penalties for failure to pay retaliatory taxes in a timely manner. Any foreign or alien insurer subject to § 38.2-1026 shall annually, on or before March 1, file a report with the State Corporation Commission which compares the regulatory costs imposed on such insurer by this Commonwealth during the preceding calendar year to the regulatory costs that would have been imposed on a similar insurer domiciled in this Commonwealth by the insurer's state of domicile during the preceding calendar year. This report shall be filed on a form and in such detail as prescribed by the Commission. Amounts owed due to the equalization of the regulatory costs imposed on the insurer by this Commonwealth and the regulatory costs of the insurer's state of domicile shall be remitted to the Commission on or before March 1 of each year. Failure of the insurer to pay the amounts required under this section before March 1 shall result in a penalty of 10% of the amount due, and interest shall be charged at a rate established pursuant to § 58.1-15 for the period between the due date the date of full payment.

Chapter 365 (House Bill 80)

This bill amends **§ 58.1-2500** and adds **§ 58.1-2510** (Taxation) relating to tax credits for retaliatory costs paid by certain insurance companies. For license years beginning on or after July 1, 1998, every qualified company shall be allowed a credit against the tax imposed by § 58.1-2501 in an amount equal to the retaliatory costs incurred during the corresponding taxable year as a result of the difference between other states' lower premium tax rates and other costs and the tax rates and costs imposed by the Commonwealth.

"Qualified company" is defined as a domestic insurance company that (i) has made a qualified investment in this Commonwealth and (ii) for license years beginning on or after July 1, 1998, maintained the employment level required for a qualified investment, such level to be measured as of December 31 of the corresponding taxable year. A "qualified investment" is an investment in this Commonwealth by a domestic insurance company or any one or more members of an "affiliated insurance group" that results in (i) an increase as of December 31, 1997 of at least 325 qualified full-time employees above the company's or group's total combined employment level in this Commonwealth on December 31, 1996 or (ii) during any taxable year beginning on or after January 1, 2001, such company or group having more than 100 qualified full-time employees in this Commonwealth during that entire taxable year.

The bill outlines in subsections C and D of § 58.1-2510 how a qualified company may apply for a credit, and how and under what circumstances unused credits will be refunded to the qualified company. Subsection E of § 58.1-2510 specifies that if two or more domestic insurance companies paying retaliatory costs in any year are members of an affiliated insurance group, the total of the retaliatory costs paid my be combined and apportioned among the members of the affiliated insurance group as the members may agree.

COMPANY LICENSING BILLS

Chapter 16 (Senate Bill 41)

This bill amends the current provisions of **Title 13.1, Chapter 3.1**, and **Title 38.2, Chapter 18** (Insurance Agents) dealing with automobile clubs to apply the same licensing and renewal processes to automobile clubs and agents that are applicable to all other entities licensed by the Bureau of Insurance. As a result of this legislation:

- Applicants for Automobile Club Agent licenses will pay a one-time $15.00 license fee and will be issued a perpetual restricted license as is the case for all other restricted licenses.
- The automobile clubs will pay a $12 annual appointment fee per agent instead of the current $2 annual renewal fee.
- The automobile clubs will pay a $200 certificate of authority renewal fee instead of the current $100 renewal fee.
- The State Corporation Commission will be given express authority to suspend, non-renew or revoke the license of a non-complying automobile club or automobile club agent.
- Agents holding a Property & Casualty Agent license (Type 30) need not obtain a separate Automobile Club Agent license.

- **NOTE:** The State Corporation Commission has always had the authority to suspend, non-renew or revoke the license of a licensed Property & Casualty Agent who was also an Automobile Club Agent. But, before Senate Bill 41, if the Automobile Club Agent was not also licensed as a Property & Casualty Agent, the Commission had no authority to discipline the Automobile Club Agent simply on the basis of his automobile club license.

INSURANCE AGENTS AND CONTINUING EDUCATION BILLS

Chapter 12 (House Bill 675)

This bill amends **§ 38.2-512** in the Unfair Trade Practices Chapter by modifying subsection A and enacting new subsections B and C to place additional consumer protections in Title 38.2 of the Code of Virginia so that insurance agents and others are prohibited from engaging in certain activities. The bill:

- extends the prohibition against misrepresentation on an insurance application to ANY insurance-related document so that no person can make false or fraudulent statements or representations with respect to any document relating to the business of insurance;
- prohibits agents and others from forging the signatures of proposed insureds, applicants, etc.;
- prohibits agents and others from obtaining the signature of the proposed insured, applicant, etc. and then using that signature to accomplish insurance-related changes to documents when such changes were not authorized by the individual who provided the signature.

Examples of some of the practices that have been engaged in by insurance agents in the past, without the knowledge of or consent by the applicant/insured, and which will be prohibited under this bill are:

* signing a policy delivery receipt without actually delivering the policy
* applying for and signing a policy loan form in the client's name
* signing and depositing a policy loan check
* signing and depositing a claim check
* changing the mode of payment to draft a client's account
* signing a replacement notice in the client's name
* falsifying a client's financial disclosure statement
* falsifying an Internal Revenue Service 1035 exchange form

Chapter 46 (Senate Bill 422)

Effective March 11, 1998

This bill makes both major and technical revisions to **§§ 38.2-1866, 38.2-1868.1, 38.2-1869** and **38.2-1872** in the Continuing Education Article of the Insurance Agents Chapter, as follows:

- The bill clarifies the term "agent" includes those holding Insurance Consultant licenses.
- The bill clarifies that the prohibition against using courses given by insurance companies or insurance agencies to account for more than 75% of the total credit hours required for an agent in any one biennium is not limited only to the company(ies) or agency with which the agent is affiliated. The Virginia Insurance Continuing Education Board (Board) may require course providers to disclose whether or not their offerings fall within the 75% limitation.
- The bill reiterates that requirements must be completed during the 24 months of the biennium, and that no extensions of time can or will be granted.
- The time provided for agents to submit proof of compliance is being extended to a full two months, in order to provide agents with more time to complete the submission process.
- In addition, agents are being given a third month to file proof of compliance, subject to payment of a $250 late filing fee.
- § 38.2-1869 is amended to place a 60-day limitation on an individual's right to appeal a license termination where termination is based upon noncompliance with continuing education requirements.
- The bill allows agents to begin completing the study course and examination requirements immediately after the end of a biennium, instead of being required to wait until after license termination, if they know they will lose their

license because of noncompliance. This will afford agents a "head start" on meeting the re-licensing requirement.

- An alternative to the current 90-day waiting period subsequent to license termination and before which the agent may not apply for relicensing has been added. Under this new provision, the agent may avoid waiting 90 days and may in lieu thereof pay an administrative penalty of $1,000. Whether under the 90-day waiting period or the $1,000 penalty, the agent must satisfactorily complete any prelicensing study course requirement and pass the prelicensing examination before re-applying for licensure.

The bill contained an emergency enactment, and it therefore took effect on the date signed by the Governor, March 11, 1998. All changes will apply to the current (1997-1998) biennium.

Chapter 47 (Senate Bill 423)

This bill amends **Chapter 18 (Insurance Agents) of Title 38.2** and adds a new section numbered **§ 38.2-514.2**. The bill establishes a new type of limited license under **§§ 38.2-1814 and 38.2-1815** for "motor vehicle rental contract insurance agents," and it amends **§ 38.2-1824** by adding the term "motor vehicle rental contract insurance" to the kinds of agents' licenses and appointments the State Corporation Commission may issue. The bill defines "motor vehicle rental contract insurance agent" in § 38.2-1800, and requires that a written disclosure be given by the agent to the prospective renter which summarizes the coverage being offered, advises the renter that he may be purchasing duplicate coverage, and states that the coverage is not required to be purchased in order to rent the vehicle.

NOTE: Because "motor vehicle rental contract insurance" may include both Life and Health and Property and Casualty lines, those agents holding appropriate general authority (Life and Health agent and/or Property and Casualty agent) need not obtain a separate motor vehicle rental contract insurance agent license.

Chapter 129 (Senate Bill 224)

This bill **repeals Chapter 53, Title 38.2, thereby removing** responsibility for certification of Private Review Agents from the Bureau of Insurance and enacts provisions in **Title 32.1** which instead place that responsibility with the Department of Health. The Department of Health is to consult with the appropriate health regulatory board in the Department of Health Professions if there is a question concerning compliance with standards of practice governing a health care profession.

A third enactment clause provides that regulations previously promulgated by the Commission regarding private review agents shall continue in effect and be deemed

regulations of the Department of Health until either (i) the effective date of Department of Health regulations or (ii) January 1, 2000.

Records necessary for administering this bill must be transferred by the Commission to the Department of Health on or before the effective date of the bill.

Chapter 164 (House Bill 1281)

This bill amends **§§ 38.2-1800, 38.2-1814, and 38.2-1824** in the Insurance Agents Chapter by establishing a new limited license type for agents selling "pet accident, sickness, and hospitalization insurance." These agents will be able to sell pet accident, sickness, and hospitalization insurance without being licensed as full Property and Casualty Agents, and they will not have to take the pre-licensing study course, written exam, or comply with the continuing education requirements.

NOTE: Agents holding a full Property & Casualty Agent license need not obtain a separate Pet Accident, Sickness, and Hospitalization Insurance license.

LIFE AND HEALTH BILLS

NOTE: More than one of the following bills creates a new § 38.2-3418.3. The Virginia Code Commission will assign actual section numbers to each after it meets. Therefore, the sections cited in these bill may differ when the actual Code updates are printed.

Chapter 11 (House Bill 567)

This bill amends **§§ 38.2-5701** and **38.2-5702** in the Viatical Settlements Act to add language to subdivisions 38.2-5701 A (1) and (2), and 38.2-5702 A (1) and (2) setting forth how the application and renewal fees received from viatical settlement providers and brokers will be handled.

Subsection **38.2-5701 F** is revised to require that nonresident viatical settlement providers appoint a resident of the Commonwealth as agent for service of process, and that in the event the viatical settlement provider fails to appoint or maintain a resident agent, or that such agent can not be located, then the Clerk of the Commission shall act as agent for service of process.

Subdivisions **38.2-5702 D (iii)** and **(iv),** setting forth the reasons that the Commission may deny, suspend or revoke a viatical settlement broker license, are amended to replace language relating to viatical settlement providers found in subdivisions 38.2-5701 G (iii) and (iv). Subdivisions 38.2-5702 D (iii) and (iv) are amended to read:

> (iii) been subject to a final administrative action or has otherwise been shown to be untrustworthy or incompetent to act as a viatical settlement broker; (iv) placed or attempted to place a viatical settlement with a viatical settlement provider not licensed in this Commonwealth;

Chapter 17 (Senate Bill 58)

This bill amends **§ 38.2-316** in the Provisions Relating to Insurance Policies and Contracts Chapter pertaining to policy forms filed with the State Corporation Commission. The Amendment adds the term "enrollment form" to § 38.2-316 B thereby providing that no individual certificate or "enrollment form" may be used in connection with any group life insurance policy, group accident and sickness insurance policy, group annuity contract, or group variable annuity contract unless such form has been filed with the Commission.

The term "enrollment form" is also added to § 38.2-316 C 1 thereby requiring that enrollment forms used in connection with policies, contracts, and certificates must be approved by the Commission prior to being delivered or issued for delivery in this Commonwealth.

In § 38.2-316 D, "enrollment form" is added to a list of documents that the Commission may disapprove or withdraw approval of for the reasons stated in this subsection.

Chapter 24 (House Bill 781)

This bill contains technical corrections to the legislation passed last year to implement the requirements imposed by the federal Health Insurance Portability and Accountability Act. The bill amends **§§ 38.2-3430.2, 38.2-3430.4, 38.2-3430.6 38.2-3431, 38.2-34321, 38.2-3432.2, 38.2-3432.3, 38.2-3435** in the Provisions Relating to Accident and Sickness Insurance Chapter, and **38.2-3514.2** and **38.2-3531** in the Accident and Sickness Insurance Policies Chapter.

The bill clarifies that for purposes of determining the aggregate periods of creditable coverage under **§ 38.2-3430.2 B 1** (i), a period of creditable coverage is not counted if there was a 63-day period during all of which the individual was not covered under any creditable coverage or was not serving a waiting period under a group health plan or group health coverage or in an affiliation period.

Section 38.2-3430.4 1 is amended to clarify that the limit applies to eligible individuals who live, reside or work in the service area.

A citation in **§ 38.2-3430.6** is corrected from § 38.2-3427 to § 38.2-3430.3.

Amendments are made in **§ 38.2-3431** to correct a reference to the Social Security Act, reference "federal" regulations for a public health plan, delete the definition of "established geographic services area," delete unnecessary language in the definition of "medical care," add a definition of "service area" and add clarifying language to the definition of "waiting period."

Section 38.2-3431 C is amended to clarify that the essential and standard health benefit plans must be offered subject to the provisions of § 38.2-3432.2.

Subdivision 38.2-3432.1 A 11 is amended to change a cross reference to subdivision 10.

Section 38.2-3432.2 is revised to clarify that if coverage is offered in the small employer market, it must be offered to all eligible employees of every small employer that applies and their dependents, including late enrollees. No eligible employees or their dependents can be excluded or charged additional premiums because of their health status. The language clarifies that all products approved for sale in the small group market that a health issuer is actively marketing must be offered to all small employers, and every employer that applies must be accepted.

Subsection 38.2-3432.2 J is revised to delete the phrase "as a late enrollee for coverage."

Subsections 38.2-3432.2 K and **L** are revised to correct cross references.

Subsection N is added to **§ 38.2-3432.3** to include provisions for late enrollees. The language clarifies that a late enrollee may be excluded for up to 18 months or may have a pre-existing limitation for 12 months, but in no case can a late enrollee be restricted from some or all coverage for more than 18 months. Individuals are not to be considered late enrollees if they meet certain conditions listed in the subsection. Individuals may be considered late enrollees for benefit riders or enhanced coverage levels not covered under their previous plan.

Section 38.2-3435 is revised to delete the exclusion of the article to non-federal governmental plans.

Section 38.2-3514.2 is revised to add individual health coverage to the list of policies to which the renewability section does not apply.

Section 38.2-3531, that includes additional exclusions and limitations, is revised to clarify that the section does not apply to group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis to employees and dependents.

Chapter 25 (House Bill 782)

Effective March 9, 1998

This bill addresses a "loophole" that was created during the implementation of HIPAA last year. It amends the HIPAA implementation article by adding **§ 38.2-3430.3.1**, applicable to individuals that qualified to meet the definition of "eligible individual" in § 38.2-3430.2 between April 29, 1997 and January 1, 1998. The bill provides that such individuals, if not currently eligible for or enrolled in a group health plan that would provide coverage for pre-existing conditions or Part A or Part B of Title XVIII of the Social Security Act, must be offered a choice of all individual health coverages being offered by health insurance issuers. The coverage selected must be issued regardless of whether individual coverage was obtained during the above time period if the existing coverage is replaced with new coverage.

The coverage required by this bill must not impose any pre-existing condition exclusion. Health insurance issuers are also prohibited from limiting or excluding coverage for named conditions.

This bill included an emergency clause, and thus took effect immediately upon enactment on March 9, 1998. The bill also included a "sunset" provision pursuant to which its provisions will expire on January 1, 1999.

Chapter 26 (House Bill 854)

This bill amends **§§ 38.2-3431 and 38.2-3433** in the Provisions Relating to the Accident and Sickness Chapter to delete the definition of "primary small employer" and the use of the term. The bill provides that the rating provisions in § 38.2-3433 that formerly applied only to primary small employers will now apply to all employer groups with up to 50 employees. The rating provisions apply to the essential and standard plans.

Chapter 49 (Senate Bill 553)

This bill amends **§ 38.2-3407.3** in the Provisions Relating to Accident and Sickness Insurance Chapter relating to the calculation of cost-sharing, adding a provision addressing out-of-state services.

The amendment to § 38.2-3407.3 A provides that when an insured, subscriber or enrollee receives covered services outside of the insurer's, health services plan's or health maintenance organization's (health plan) provider network through **another** health plan's provider network located outside of this Commonwealth, then the health plan may calculate the cost-sharing of such insured, subscriber or enrollee by using the cost of covered services as reported by the out-of-state health plan.

Chapter 56 (Senate Bill 679)

This bill adds **§ 38.2-3418.3** in the Provisions Relating to Accident and Sickness Insurance Chapter, and amends **§ 38.2-4319** in the Health Maintenance Organization Chapter. The bill requires health carriers to provide coverage for reconstructive breast surgery. The requirement applies to all insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services. The bill applies to any insurance policies, contracts or plans delivered, issued for delivery, or renewed on or after July 1, 1998.

The bill defines "reconstructive breast surgery" as surgery performed on and after July 1, 1998 (i) coincident with a mastectomy performed for breast cancer or; (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. "Mastectomy" is defined as the surgical removal of all or part of the breast on or after July 1, 1998, as a result of breast cancer. The reimbursement for reconstructive breast surgery shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. The coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

The provisions of this section do not apply to short-term travel, accident only, limited or specified disease policies (except policies issued for cancer) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare; any other similar coverage under state or federal governmental plans; or to short-term nonrenewable policies of not more than six months' duration.

Chapter 120 (House Bill 673/Senate Bill 251)

This bill amends the Mandated Benefits Article of **Chapter 34** (Provisions Relating to Accident and Sickness Insurance) and amends **§ 38.2-4319** in the Health Maintenance Organization Chapter to require coverage for hemophilia and congenital bleeding

disorders. The bill adds **§ 38.2-3418.3** to require that each insurer issuing individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group subscription contracts; and each health maintenance organization providing a health care plan to provide coverage for hemophilia and congenital bleeding disorders. The requirement applies to policies, contracts or plans delivered, issued for delivery or renewed on and after July 1, 1998.

The bill defines the terms "blood infusion equipment," "blood product," "hemophilia," "home treatment program," and "state-approved hemophilia treatment center."

The bill also requires that benefits be provided for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits are to include coverage for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

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. The amended bill does not apply to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or to any other similar coverage under state or federal governmental plans.

Chapter 146 (House Bill 1234)

This bill amends **§§ 38.2-3408** in the Provisions Relating to Accident and Sickness Insurance Chapter and **38.2-4221** in the Health Services Plan Chapter by adding "licensed acupuncturist" to the list of providers that are mandated to receive direct reimbursement.

Chapter 148 (Senate Bill 462)

This bill amends **§ 38.2-3407.4:1** in the Provisions Relating to Accident and Sickness Insurance Chapter to require the State Corporation Commission to adopt a uniform referral form for use by any health care entity defined as a "utilization management organization" by the Health Care Financing Administration (HCFA) for its Electronic Data Interchange (EDI). In developing the uniform referral form, the Commission is required to incorporate only the data elements adopted by HCFA for its EDI standards. Because of the reliance upon adoption of standards by HCFA, the Commission is not expected to take any action on this bill until after HCFA standards are made final.

Once adopted by the Commission, all such entities that require their insureds or enrollees to obtain a written referral must use the uniform referral form as the only instrument for referrals, and are prohibited from imposing, as a condition of coverage, any requirement to modify the uniform referral form or submit additional referral forms.

Chapter 154 (House Bill 855)

This bill revises **§§ 38.2-3323, 38.2-3324, 38.2-3331, 38.2-3525, 38.2-3526, 38.2-3533, 38.2-3543.1, 38.2-4214 and 38.2-4319, adds §§ 38.2-3318.1 through 38.2-3322.2, 38.2-3521.1 through 38.2-3523.4 and 38.2-3543.2,** and repeals **§§ 38.2-3318 through 38.2-3322 and 38.2-3521 through 38.2-3524**, relating to group life and group accident and sickness insurance policies and delivery requirements.

This bill adds **§ 38.2-3318.1** which sets forth the requirements for delivery of certain group life insurance policies in Virginia. The following is a list of the groups identified:
§ 38.2-3318.1 A employee groups
§ 38.2-3318.1 B credit groups
§ 38.2-3318.1 C labor unions
§ 38.2-3318.1 D multiple employer welfare arrangements and trusts
§ 38.2-3318.1 E associations
§ 38.2-3318.1 F credit unions
§ 38.2-3318.1 G incorporated associations (burial societies) with a primary purpose of financial planning for funerals and burials

This bill adds **§ 38.2-3319.1** which sets forth the limits of offering group life insurance to a resident of Virginia for groups that do not fall under **§ 38.2-3318.1. Section 38.2-3319.1 A** requires that group life insurance policies delivered in Virginia must not be contrary to Virginia's public policy; that such policies result in economies of acquisition or administration; and that the benefits provided by these policies are reasonable in relation to the premiums charged. **§ 38.2-3319.1 B** requires that the group life insurance policy be approved by the Commission or a state having substantially similar requirements, and that the insurer offering the group coverage provide certification and documentation stating that such coverage is in compliance with § 38.2-3318.1. Premium must be paid from policyholder funds or funds from covered persons or both. Insurer may exclude person if not insurable.

This bill adds **§ 38.2-3319.2** to authorize the Commission to review the records of any insurer issuing group life insurance policies to determine that the policies issued are in compliance.

This bill adds **§ 38.2-3320.1** which provides that group life insurance policies issued outside of Virginia which provide coverage to residents of Virginia that do not qualify under § 38.2-3318.1 or do not comply with § 38.2-3319.1 shall be subject to the statutory requirements of Title 38.2 and insurer is subject to penalties under Title 38.2.

This bill adds **§ 38.2-3321.1** which sets forth the requirement that individuals marketing group life insurance policies that do not qualify under § 38.2-3318.1 must hold a valid life and health insurance agent license as required by § 38.2-1800 et seq.

This bill adds **§ 38.2-3322.1** which provides the Commission with the authority to issue regulations.

This bill also adds **§ 38.2-3322.2** which requires that group life insurance policies shall cover at least two people.

This bill amends **§ 38.2-3323** relating to group life insurance coverages for spouses, minor dependent children and dependent handicapped children. The term "group credit life insurance" is replaced with § 38.2-3318.1 B as an exception to group policies that may be extended to insure spouses or children.

This bill amends **§ 38.2-3324** relating to exceptions to the standard provisions prescribed. The term "group credit life insurance" is replaced with § 38.2-3318.1 B as an exception to group policies that fall under §§ 38.2-3330 A, 38.2-3331, and 38.2-3332 through 38.2-3334.

This bill amends **§ 38.2-3331** relating to individual certificates. The term "group credit life insurance" is replaced with § 38.2-3318.1 B, which requires that when a debtor pays any part of a credit insurance premium, the insurer shall provide the policyholder with a form to be delivered to the debtor stating that any death benefit paid under the policy will go toward paying the debt.

This bill adds **§ 38.2-3521.1** which sets forth the requirements for delivery of certain group accident and sickness insurance policies in Virginia. The following is a list of the groups identified:

§ 38.2-3521.1 A employee groups
§ 38.2-3521.1 B credit groups
§ 38.2-3521.1 C labor unions
§ 38.2-3521.1 D multiple employer welfare arrangements and trusts
§ 38.2-3521.1 E associations
§ 38.2-3521.1 F credit unions
§ 38.2-3521.1 G health maintenance organizations

This bill adds **§ 38.2-3522.1** which sets forth the limits of offering group accident and sickness insurance to a resident of Virginia for groups that do not fall under § 38.2-3521.1. Section 38.2-3522.1 A requires that group accident and sickness insurance policies delivered in Virginia must not be contrary to Virginia's public policy, would result in economies of acquisition or administration, and that the benefits are reasonable in relation to the premiums charged. Section 38.2-3522.1 B requires that

the group accident and sickness insurance policy must be approved by the Commission or a state having substantially similar requirements, and that certification from the insurer offering the group coverage state that such coverage is in compliance with § 38.2-3521.1. Attached to the certification must be documentation from such state evidencing the determination that such requirements have been met. Insurers offering group accident and sickness insurance that are unable to meet the requirements of § 38.2-3522.1 B shall be required to file policy forms with the Commission for approval pursuant to § 38.2-316. Premiums must be paid by policyholder's funds or covered persons fund or both. An insurer may exclude or limit coverage for those considered not insurable.

This bill adds **§ 38.2-3523.1** authorizes the Commission to review the records of any insurer issuing group accident and sickness insurance policies to determine that the policies issued are in compliance. Insurers not complying with §§ 38.2-3521.1 and 38.2-3522.1 will be deemed to have committed a knowing and willing violation subject to § 38.2-218.

This bill adds **§ 38.2-3523.2** which provides that group accident and sickness insurance policies issued outside of Virginia, which provide coverage to residents of Virginia that do not qualify under § 38.2-3521.1 or § 38.2-3522.1, shall be subject to the statutory requirements of Title 38.2, and the insurer is subject to penalties under Title 38.2.

This bill adds **§ 38.2-3523.3** which sets forth the requirement that individuals marketing group accident and sickness insurance policies that do not qualify under § 38.2-3521.1 or § 38.2-3522.1 must hold a valid life and health insurance agent or health agent license as required by § 38.2-1800 et seq.

This bill adds **§ 38.2-3523.4** which requires that at least two people be covered under group accident and sickness insurance policies.

This bill amends **§ 38.2-3525** relating to group accident and sickness insurance coverages of spouses and dependent children. The term "group credit accident and sickness insurance policy" is replaced with § 38.2-3521.1 B as an exception to group policies that may be extended to insure spouses or children.

This bill amends **§ 38.2-3526** relating to exceptions to the standard provisions required. The term "group credit accident and sickness insurance" is replaced with § 38.2-3522 B as an exception to group policies that fall under §§ 38.2-3531 A, 38.2-3533 and 38.2-3538.

This bill amends **§ 38.2-3533** relating to individual certificates. The term "credit accident and sickness" is replaced with § 38.2-3522.1 B, which requires that when a debtor pays any part of a credit insurance premium, the insurer shall provide the policyholder with a form to be delivered to the debtor stating that any benefit paid under the policy will go toward paying the debt.

This bill revises **§ 38.2-3543.1** which provides the Commission with the authority to establish rules and regulations for coordination of benefits, and adds language allowing the Commission to establish standards to be met in connection with the marketing and contracting for group accident and sickness insurance.

This bill also adds **§ 38.2-3543.2** which provides that in the event of any conflict between the provisions of this article and other provisions of Title 38.2, the provisions of this article shall be controlling.

This bill amends **§ 38.2-4214**, which provides that no provision of Title 38.2, except for Chapter 42 and certain sections listed, shall apply to the operation of a plan, to include §§ 38.2-3522.1 through 38.2-3523.4 and 38.2-3543.2.

Section 38.2-4319, which provides that no provision of Title 38.2 except for Chapter 43 and certain sections listed shall apply to any health maintenance organization granted a license under this chapter, is amended to include §§ 38.2-3522.1 through 38.2-3523.4 and 38.2-3543.2.

Chapter 356 (Senate Bill 372)

This bill **repeals the "sunset clause"** from the genetic information privacy provisions in **§ 38.2-508.4** of the Unfair Trade Practices Chapter. This means that the genetic information privacy provisions will continue indefinitely instead of expiring on July 1.

Chapter 625 (House Bill 1413)

This bill amends the Mandated Benefits Article of **Chapter 34** (Provisions Relating to Accident and Sickness Insurance) and amends **§ 38.2-4319** in the Health Maintenance Organizations Chapter to require health carriers to provide coverage for early intervention services. The bill adds **§ 38.2-3418.3** and requires each insurer issuing individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; each corporation providing individual or group subscription contracts; and each health maintenance organization providing a health care plan to provide coverage for medically necessary early intervention services. The requirement applies to policies, contracts or plans delivered, issued for delivery or renewed on and after July 1, 1998.

The amended bill limits benefits to $5,000 per insured or member per policy or calendar year and, except as set forth in subsection C, shall be subject to such dollar limits, deductibles and coinsurance factors as are no less favorable than for physical illness generally.

The bill defines “early intervention services,” “financial costs” and “medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services.” The bill also prohibits the cost of early intervention services from being applied to any contractual provision limiting the total amount of coverage paid by the insurer, corporation or health maintenance organization to or on behalf of the insured or member during the insured’s or member’s lifetime.

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, nor does it apply to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans.

Chapter 631 (House Bill 542)

This bill adds **§ 38.2-3418.3** to the Provisions Relating to Accident and Sickness Chapter; amends **§ 38.2-4319** in the Health Maintenance Organization Chapter, § 2.1-20.1 in the Commonwealth Employee Health Plan Chapter and § 32.1-325 in the Medicaid Chapter. The bill requires coverage for a minimum hospital stay following mastectomy surgery. It affects the state employee health insurance plan, Medicaid, and all insurers proposing to issue individual and group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services. The bill applies to any insurance policies, contracts or plans delivered, issued for delivery, reissued, or renewed on or after July 1, 1998.

Chapter 709 (House Bill 915/Senate Bill 705)

This bill adds **§ 38.2-3418.3** to the Provisions Relating to Accident and Sickness Insurance Chapter. The bill also amends **§ 38.2-4319** in the Health Maintenance Organization Chapter, **§ 2.1-20.1** in the Commonwealth Employee Health Plan Chapter and **§ 32.1-325** in the Medicaid Chapter. The bill requires the state employee health insurance plan, Medicaid, and all insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services to provide coverage (i) to persons age fifty and over and (ii) to persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society (ACS), for one prostate-specific antigen

(PSA) test in a twelve-month period and digital rectal examinations, in accordance with the ACS's guidelines. The bill applies to any insurance policies, contracts or plans delivered, issued for delivery, reissued, or renewed on or after July 1, 1998.

The bill defines "PSA testing" as the analysis of a blood sample to determine the level of prostate-specific antigen.

The provisions of this section do not apply to (i) short-term travel, accident only, limited or specified disease policies other than cancer policies; (ii) short-term nonrenewable policies of not more than six months' duration; or (iii) policies or contracts for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

Chapter 891 (Senate Bill 712)

This bill revises **§§ 38.2-511, 38.2-4214, 38.2-4301, 38.2-4302, 38.2-4307, 38.2-4312, 38.2-4316, 38.2-4319** and **38.2-4509**. It repeals **§§ 38.2-4308** and **38.2-4311**. It also repeals **§§ 38.2-5400** through **38.2-5409** (**Chapter 54 of Title 38.2**) and reconstitutes similar utilization review provisions in **Chapter 5** of **Title 32.1** in a new **Article 1.2** at **§§ 32.1-137.7** through **32.1-137.16**. In addition, the bill adds a new **Chapter 58** in **Title 38.2 (§§ 38.2-5800 through 38.2-5811**) and a new article in **Chapter 5** of **Title 32.1** (**§§ 32.1-137 through 32.1-137.6**) to address "managed care health insurance plans" (MCHIPs). The bill also revises **§ 32.1-5** and amends subsection B of Virginia's Freedom of Information Act (**§ 2.1-342**).

Amendments in **Title 32.1** are the regulatory responsibility of the Virginia Department of Health and the State Health Commissioner. Amendments in **Title 38.2** are the regulatory responsibility of the State Corporation Commission when acting through the Bureau of Insurance in the regulation of health insurers, health services and hospital services plans, health maintenance organizations, and dental and optometric services plans. The following describe primarily the amendments in **Title 38.2**.

Amendments at **§ 38.2-511** revise the record retention requirements of Virginia's Unfair Trade Practices Act for Insurers to ensure that a health carrier's records of complaints are retained for no less than five years. This time-frame acknowledges that examinations under § 38.2-1317 shall be conducted at least once every five years.

Amendments at **§ 38.2-4214** sweep-in Chapter 58 (MCHIPs) thereby applying managed care provisions to the operations of any health services or hospital services plan that meets the definition of a managed care health insurance plan.

At **§ 38.2-4301,** the requirements that licensing applications include descriptions of service areas, complaint systems and procedure assuring availability and accessibility

and assessing quality of health care services have been removed. Other provisions in the bill replicate these requirements in Title 32.1 as required filings when applying for quality assurance certification. Related provisions in the new § 32.1-137.2 describe more fully the expectations for complaint resolution and access, adequacy and continuity, including considerations for networks, service areas and geographical areas. The provision requiring HMOs to file a material change notice within 30-days after there is a change in information disclosed in a licensing application has been deleted also; however, a similar requirement has been added at § 38.2-5802..

New language at **§ 38.2-4302** adds specific reference to the new Chapter 58 thereby acknowledging that provisions pertinent to the operation of managed care health insurance plans are conditions of licensure**.**

Technical revisions at **§ 38.2-4307** delete direct reference to the State Health Commissioner and add specific reference to the new Chapter 58.

Amendments at **§ 38.2-4312** strike provisions appearing in subdivisions C and G and replicates them in Chapter 58 for application to all MCHIPs pursuant to § 38.2-5806.

Amendments at **§ 38.2-4316** delete provisions that are replicated in the new § 38.2-5809 authorizing suspension or revocation of an HMO's license if it is determined that the HMO or other responsible health carrier is unable to furnish quality assurance or has failed to implement the complaint system required of MCHIPs.

Amendments at **§ 38.2-4319** sweep-out Chapter 54 (utilization review) and sweep-in Chapter 58 (MCHIPs).

Amendments at **§ 38.2-4509** sweep-in Chapter 58 to recognize that the dental and optometric services plans regulated under Chapter 45 will be subject also to provisions in Chapter 58 if the plans fit the definition of managed care health insurance plan. A new provision notes that the utilization review provisions in Title 32.1 shall not apply to dental and optometric services plans.

A new **§ 38.2-5800** defines the key terms used in Chapter 58, including "MCHIP" or "managed care health insurance plan", "health carrier", and "covered person."

The new **§ 38.2-5801** contains general provisions, which prohibit the operation of an MCHIP in this Commonwealth unless a health carrier that directly or indirectly manages, owns, contracts with, or employs the providers for the plan is licensed in accordance with Virginia's insurance statutes (Title 38.2 of the Code of Virginia) and subject to regulation as a health carrier responsible for compliance with provisions in the new Chapter 58. The provisions require the health carrier for an MCHIP to request a certificate of quality assurance from the Department of Health in accordance with provisions in Title 32.1 at § 32.1-137.2.

Section 38.2-5802 sets forth provisions for the establishment of a managed care health insurance plan (MCHIP). Effective July 1, 1998, health carriers will be required to file, with their license applications and requests for renewal, information describing the nature of their MCHIP operations; lists of providers and forms of contracts with providers may be required also; however, individual contracts and contracts with persons outside Virginia shall not be filed unless specifically requested and needed. The new provisions anticipate interaction with the Department of Health and require the health carrier to give notice to the State Health Commissioner each time an MCHIP filing is made with the State Corporation Commission under this section.

Section 38.2-5803 requires that the covered persons be advised concerning the complaint systems, the service areas, the names and locations of providers, and the regulatory oversight that is provided by the State Corporation Commission Bureau of Insurance and the Virginia Department of Health. Additional disclosure requirements are set forth for MCHIPs that require a covered person to select a primary care physician with respect to the offer of basic health care services.

Provisions at **§ 38.2-5804** require health carriers for all MCHIPs to establish complaint systems which have been approved by the State Health Commissioner and the State Corporation Commission Bureau of Insurance.

Section 38.2-5805 replicates, with technical modifications, provisions being deleted from **§ 38.2-4311**. These provisions require MCHIPs to maintain lists of providers and written contracts which in some instances shall contain statutory "hold-harmless" provisions.

Section 38.2-5806 prohibits cancellations and refusals to renew due to the health status of an enrollee and, additionally, puts the health carriers for MCHIPs on notice as to arbitration agreements and procedures which may be required pursuant to provisions in Title 32.1 or regulations promulgated thereunder; such provisions would prohibit restraints against, or imposition of, arbitration, except on claims less than $250, while preserving the covered person's right to agree to arbitration.

Section 38.2-5807 identifies "access to care" as a quality assurance issue to be assessed by the Department of Health in accordance with provisions in Title 32.1.

Section 38.2-5808 concerns the examination of MCHIP operations. It authorizes examination coordination and acknowledges the quality assurance and complaint system responsibilities of the State Health Commissioner.

Section 38.2-5809 sets forth provisions which require the State Corporation Commission to suspend or revoke the license of a health carrier upon notice that a certificate of quality assurance has been revoked.

Section 38.2-5810 addresses statutory construction and relationship to other laws.

Section 38.2-5811 states that the Commission shall have no jurisdiction to adjudicate controversies between a MCHIP and its covered persons.

NOTE: These provisions in Title 38.2 should be read in conjunction with the new provisions in Articles 1.1 and 1.2 of Chapter 5 of Title 32.1, §§ 32.1-137.1 *et seq.* and 32.1-137.7 *et seq.*, respectively.

Chapter 908 (House Bill 1075)

This bill amends **§§ 38.2-4214** and **38.2-4319** and adds **§ 38.2-3407.12** to require that every health care plan offered by an HMO shall provide or include, or the HMO shall arrange for or contract with another carrier to provide or include, a point-of-service (POS) benefit as an additional benefit for the enrollee (i.e. the employee), at the enrollee's option. The HMO must make the POS benefit available to a group contract holder unless the HMO determines in good faith that another health carrier is already offering the group contract holder's enrollees a plan that provides a POS benefit.

The new statute defines significant terms, describes required disclosures, prescribes certain aspects of rating, underwriting, coinsurance and premium determination; and requires also that any premium differential and any group specific administrative costs charged to enrollees must be actuarially sound and supported by sworn certificates of an officer.

The new provisions apply to all group health benefit plans issued or renewed by carriers on or after July 1, 1998. Plans which are self-funded or self-insured are not affected by the statute.

PROPERTY AND CASUALTY BILLS

Chapter 69 (Senate Bill 554)

This bill amends **Chapter 1.3 of Title 6.1** known as the Consumer Real Estate Settlement Protection Act (CRESPA). **Section 6.1-2.19** is amended to state that a real estate agent or such agent's employees or independent contractors may perform settlement services without complying with CRESPA as long as that person is not listed as the settlement agent on the settlement statement and is not otherwise prohibited from performing such services. The definition of settlement agent in **§ 6.1-2.20** is amended to say that a settlement agent is the person listed on the settlement

statement. The term "settlement statement" is also defined. In **§ 6.1-2.21**, the requirement that an annual audit be performed has been changed to require that an audit be conducted at least once each consecutive 12-month period and reported to the licensing authority no later than 60 days after the audit is completed. Also, in **§ 6.1-2.21 E 2** the word "audit" has been changed to "analysis," and the language now states that a title insurance company's analysis of its title insurance agents' escrow accounts must be done in accordance with the regulations promulgated by the State Corporation Commission or the guidelines issued by the Bureau of Insurance. **Section 6.1-2.23** has been amended to require that all settlement statements identify the name and address of the settlement agent.

Chapter 141 (House Bill 883)

This bill amends **§ 38.2-2212** in the Liability Insurance Policies Chapter by making two clarifications. The first change deletes reference to the obsolete term "medical payments coverage" in subsection C 1 o since medical payments coverage is no longer available. (It was combined with medical expense coverage under House Bill No. 727 in 1991.) The second change deletes reference to the policy's *anniversary* date in subsection D 1 in order to make it clear that the 90-day underwriting period precedes the last effective date of the policy, not the policy's anniversary date. The current language in the Code of Virginia contemplates policies written for 12 months while most policies today are written for six months.

Chapter 142 (House Bill 884)

This bill amends **§§ 38.2-231** (commercial auto and commercial liability termination provisions), **38.2-2114** (homeowners termination provisions), and **38.2-2212** (private passenger auto termination provisions) by clarifying that the insured does not need to make a termination request in writing if the insurer does not require it to be in writing. With the amended language, the Code of Virginia will reflect the fact that the company has the option of either requiring or not requiring the insured's request to be given in writing. Companies that allow insureds to make termination requests orally, rather than in writing, must have the appropriate forms on file with the Bureau.

Chapter 162 and Chapter 736 (House Bill 1265 and Senate Bill 281)

These bills amend **§ 6.1-2.19** of the Consumer Real Estate Settlement Protection Act (CRESPA) by stating that a real estate agent or such agent's employees or independent contractors may perform settlement services without complying with CRESPA as long as that person is not listed as the settlement agent on the settlement statement and is not otherwise prohibited from performing such services.

Chapter 404 (House Bill 327)

This bill amends **§§ 46.2-706** and **46.2-708** of the Motor Vehicle Code by increasing the uninsured motorist fee. The fee will go from $400 to $500.

Chapter 590 (Senate Bill 421)

Effective January 1, 1999 and Expires January 1, 2003

This bill amends **Titles 38.2** and **58.1** and adds a new chapter to **Title 52** to create a fraud unit within the Department of State Police. The Fraud Investigation Unit will initiate independent inquiries and conduct independent investigations into fraudulent acts involving property and casualty insurance transactions. The definition of insurance fraud is limited to property and casualty lines of insurance. The fraud unit will be funded by premium assessments on all property and casualty insurance companies writing policies in Virginia. The bill also requires all insurance applications and all claim forms to contain a statement, permanently affixed to, or included as a part of the application or claim form, that states in substance the following: "*It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits*." **Any applications for insurance that attach to and form a part of the policy must be submitted to the Bureau of Insurance for approval. An application that is not a part of the policy should not be submitted for approval.**

Chapter 598 (Senate Bill 684)

This bill amends **§ 6.1-2.20** of the Consumer Real Estate Settlement Protection Act (CRESPA) by expanding the definition of "party to the real estate transaction" to include any entity which is a subsidiary of or under common ownership with a corporate purchaser in a real estate transaction. A party to the real estate transaction is exempt under CRESPA from being licensed as a settlement agent.

Chapter 726 (House Bill 1353)

This bill adds a new section numbered **§ 38.2-2232** in the Liability Insurance Policies Chapter which requires insurers issuing new or renewal policies covering the liability of private pleasure watercraft to offer uninsured private pleasure watercraft coverage. The insurer must offer, in writing, to the named insured the option of purchasing coverage undertaking to pay **all sums** the insured is legally entitled to recover as damages from the owner or operator of an uninsured private pleasure watercraft arising

out of the ownership, maintenance, or use of such uninsured watercraft. Insurers issuing excess or umbrella policies are not required to offer this coverage. In addition, insurers issuing policies which provide liability coverage incidental to a policy and not related to a specifically insured private pleasure watercraft (i.e. homeowners policies) are not required to offer this coverage. Also, the bill defines an uninsured private pleasure watercraft as one for which there is no liability insurance.

FINANCIAL REGULATION BILLS

Chapter 42 (Senate Bill 248)

This bill amends various sections of the Code of Virginia dealing with the financial regulation of certain insurers. **§ 38.2-203** is amended to extend to health maintenance organizations, legal services plans, dental and optometric services plans and premium finance companies requires that the management and exclusive agency contracts be filed with and receive prior approval from the State Corporation Commission. Related amendments conform sweep-in provisions at **§§ 38.2-4319 and 38.2-4509.**

Amendments at **§ 38.2-1322** define "insurer" for purposes of applying the insurance holding company statutes as including both insurance companies and health maintenance organizations. This amendment means that health maintenance organizations will now be subject to the holding company statutes contained in **Chapter 13**, and the related rules appearing in the Commission's Rules Governing Insurance Holding Companies at **14 VAC 5-260-10 et seq**.

Section 38.2-4309 is amended to broaden the investment authority of health maintenance organizations and to make the investments of entities licensed under Chapter 43 (Health Maintenance Organizations) of Title 38.2 subject to regulation pursuant to Chapter 14 (Investments) of Title 38.2.

Section 38.2-1401 is amended to include Chapter 43's health maintenance organizations in the definitions of "insurer" and "minimum capital and surplus" contained in Chapter 14.

Section 38.2-4302 is amended by adding a new **subdivision A 3 F** specifying net worth requirements and a new **subsection B** applying minimum net worth requirements to all health maintenance organizations. A health maintenance organization seeking to be licensed under Chapter 43 shall have and maintain a minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than $600,000, up to a maximum of $4 million; uncovered expenses shall be amounts determined for

the most recently ended calendar quarter pursuant to regulations promulgated by the Commission.

If the Commission finds an impairment of the minimum net worth of a domestic health maintenance organization, the Commission shall issue an order requiring the health maintenance organization to eliminate the impairment within a 90-day period. If the Commission finds an impairment of the minimum net worth of a foreign health maintenance organization, the Commission may order the health maintenance organization to eliminate the impairment and restore the minimum net worth to the amount required by this section. If the health maintenance organization fails to comply with the Commission's order, the Commission may suspend or revoke the license of the health maintenance organization as provided in § 38.2-4316.

Prior to December 31, 1999, a health maintenance organization with less than the minimum net worth which is licensed on and after June 30, 1998 may continue to operate as a licensed health maintenance organization with a finding of impairment if the licensee has net worth:

(i) on June 30, 1998 and up to December 31, 1998, in an amount at least equal to the sum of uncovered expenses, but not less than $300,000, up to a maximum of $2 million;

(ii) on December 31, 1998 and up to June 30, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $400,000, up to a maximum of $2.5 million; and

(iii) on June 30, 1999 and up to December 31, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $500,000, up to a maximum of $3 million.

Chapter 48 (Senate Bill 447)

This bill amends **§ 6.1-58.2** (Banking and Finance Title) relating to controlled subsidiaries and the transaction of insurance business. In addition to the types of businesses authorized in § 6.1-58.2, a controlled subsidiary corporation may be formed to underwrite reinsurance of mortgage guaranty insurance on loans secured by real estate made or purchased by such controlled reinsurance subsidiary's affiliates or by a bank or banks owning such controlled subsidiary, provided that such controlled subsidiary corporations transact only the insurance business specifically permitted by this section. Such controlled subsidiary shall be subject to the further provisions of Title 38.2 otherwise applicable to insurance companies transacting a comparable business.

For purposes of this section, a controlled subsidiary corporation may be a domestic or foreign corporation, and the majority of its voting stock may be owned directly or indirectly by (i) a bank or banks organized under the laws of the United States; (ii) a bank or banks organized under the laws of this Commonwealth; (iii) a bank or banks organized under the laws of one of the other states of the United States; or (iv) a "bank holding company" owning a bank or banks in this Commonwealth or in another state.

Chapter 230 (Senate Bill 64)

This bill amends various sections of **Chapter 16** (Virginia Property and Casualty Insurance Guaranty Association) of **Title 38.2** for the purpose of enabling the Virginia Property and Casualty Insurance Guaranty Association (Guaranty Association) to respond more effective in the event of a natural catastrophe.

The bill amends **§ 38.2-1601 9** to clarify that guaranty fund coverage does not extend to insurance written by risk retention groups. This amendment is conforming with the Federal Risk Retention Act and § 38.2-5106.

The bill amends **§ 38.2-1603** to clarify the definition of "account" so that the use of "account" in Article 1 of Chapter 16 is distinguished from the use of "account" in Article 2. The definition of "member insurer" is also amended to clarify that the term "member insurer" does not include persons listed in § 38.2-1601 9. Conforming amendments appear at **§§ 38.2-1604 and 38.2-1606**.

The bill amends **§ 38.2-1606 B** to authorize the Guaranty Association to obtain commitments or lines of credit and, in the event of a natural disaster, to secure the indebtedness with a pledge of future assessments. The new provisions define natural catastrophe, condition the borrowing and pledge on approval of the Commission, tie use of funds to provisions in § 38.2-1622, and place limits on the amount of moneys to be borrowed.

The bill amends **§ 38.2-1618** to recognize that Article 2 addresses the secured borrowings described in the new provisions at § 38.2-1606 in addition to funds already recognized by the Code of Virginia.

Chapter 318 (Senate Bill 626)

This bill amends **§ 32.1-330.3** and adds **§ 38.2-226.2** relating to the oversight of certain long-term care prepaid health plans established in accordance with federal statutes authorizing special funding for certain programs for all inclusive care for the elderly commonly known as "PACE" and pre-PACE" plans. It amends provisions in Title 32.1 that authorize oversight by the Department of Medical Assistance Services; and adds conforming provisions in Title 38.2 that exempt the covered plans from regulation

pursuant to Title 38.2. This bill provides for consistent oversight by the Department of Medical Assistance Services, with common requirements for both pre-PACE and PACE plans. It also re-establishes for pre-PACE plans the exemption from regulation by the Bureau of Insurance pursuant to Title 38.2, that expired on July 1, 1997, and extends the exemption to PACE plans.

Chapter 388 (Senate Bill 16)

Effective April 12, 1998

This bill amends **§ 65.2-1201** of the Virginia Workers' Compensation Act to increase the maximum amount of Uninsured Employers Fund tax that may be assessed against an uninsured or self-insured employer for the purpose of paying workers' compensation benefits from 1/4 of 1% to 1/2 of 1% of gross workers' compensation premiums. **This bill was effective from passage on April 12, 1998, but the fourth enactment clause to this bill states that the provisions of this act expire on July 1, 1999.**

The bill also requires the Virginia Workers' Compensation Commission to prepare a report by December 1, 1998 addressing various issues involving the Uninsured Employer's Fund (Fund), including revenue needs of the Fund, administration of claims against the Fund and oversight of self-insured employers. The Bureau of Insurance, major workers' compensation insurance carriers, self-insured employers, third party administrators of workers' compensation insurance and other interested parties are to provide evaluation and comments on the various issues, including the methodology for determining both the aggregate sum and the projected cash flow needs of the Fund.

Chapter 414 (House Bill 565)

This bill amends and reenacts provisions of **Chapter 14 in Title 38.2** concerning the investments of insurance companies. In each instance the amendments recognize additional investment authority for insurers.

The bill amends **§ 38.2-1403** to increase the size of the insurer's Category 2 "basket," thereby increasing the dollar amount of essentially unrestricted investments. Currently most insurers may invest up to 50% of their surplus to policyholders, less the statutorily required minimum policyholder surplus of $4 million dollars, without regard to statutory provisions which are aimed at encouraging diversity and liquidity in an insurer's investment portfolio. The amendments enlarge the basket by raising the percentage from 50% to 75%.

The bill amends **§ 38.2-1413 A 6** to recognize additional Category 1 investment authority for investments in obligations of certain United States agencies and instrumentalities, including securities issued or guaranteed by Fanny Mae (FNMA) and

Freddie Mac (FHLMC). The amendment doubles authority by raising the per issuer/per obligor limitation from 5% to 10% of the insurer's admitted assets.

The bill amends **§ 38.2-1415 D** to increase Category 1 authority for investing in the direct, general obligations of the various sates. Authority for investment in obligations of any one political subdivision is increased from 2% to 5% of admitted assets; and overall authority is increased from 20% to 30% of admitted assets.

The bill amends **§ 38.2-1421** and **§ 38.2-1414 A 6** to create authority for investing up to 2% of admitted assets as Category 1 investments in business entity obligations which have received a lower grade rating of "four." In all cases the rating is to be based on valuation by the Securities Valuation Office of the National Association Insurance Commissioners, or another national rating agency recognized by the State Corporation Commission.

The bill amends **38.2-1423** to simplify the quality tests for preferred stocks thereby making it easier for insurers to make Category 1 investments in preferred stocks.

The bill amends **§ 38.2-1433** and **§ 38.2-1414 A 13** to recognize new authority for making Category 1 investments in the securities of or issued in a foreign country. Such investments are recognized as Category 1 investment in amounts up to 10% of admitted assets, subject to a per jurisdiction limitation of 3% and provisions that the investment be rated medium grade or higher grade. A conforming amendment appears to § 38.2-1413.