

**COMMON PROBLEMS
IDENTIFIED DURING LIFE AND
HEALTH MARKET CONDUCT
EXAMINATIONS**

**COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE**

REVISED 2010

The State Corporation Commission's Bureau of Insurance has developed the following information to advise insurers of compliance problems frequently found in the course of Life and Health Market Conduct Examinations. Its purpose is not to provide specific guidance on how a company should conduct business in Virginia, but to point out compliance areas in which the Life and Health Market Conduct Section has discovered problems in the past. It should be noted that references within this document to Companies' failures to comply with certain statutes or regulations refer to non-compliance with all or part of such statutes or regulations.

This list should not be considered all-inclusive, and the company should continue to review [Title 38.2 of the Code of Virginia](#) (the Code), appropriate chapters of the Virginia Administrative Code (VAC), and the Bureau's administrative letters to assure compliance.

The common problems compiled in this document were identified as a result of the examinations conducted during the last 5 years. The Bureau encourages each insurer to review its current procedures to ensure the use of high and consistent compliance standards relating to market conduct activities in Virginia.

Any questions regarding this publication should be directed to:

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MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

Failure to establish and maintain a complaint system for each MCHIP. Section [38.2-5804](#) of the Code requires a health carrier to establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints. [14 VAC 5-211-150 A](#) (HMO only) states that an HMO shall establish and maintain a grievance or complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints.

The failure of an MCHIP to handle written complaints in accordance with the procedures and timeframes of the complaint system approved by the Commission can result in violations of these sections.

Failure to maintain records of written complaints. Section [38.2-5804 A 1](#) of the Code requires that a record of written complaints be maintained for no less than 5 years.

Failure to provide complaint forms and/or written procedures to persons who wish to register written complaints. Section [38.2-5804 A 2](#) of the Code states that a health carrier shall provide complaint forms and/or written procedures to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone number of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman, and shall also specify any required limits imposed by or on behalf of the MCHIP. Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions pursuant to § [32.1-137.15](#) of the Code.

Failure to maintain records of provider contracts. Section [38.2-5802 C](#) of the Code states that a health carrier shall maintain a complete file of all contracts made with health care providers, which shall be subject to examination by the Commission. The contracts shall be retained in the file for a period of at least five years after their expiration. Section [38.2-5805 C 8](#) of the Code (HMO only) states that each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract.

Failure to include the required "hold harmless" language in provider or intermediary contracts (HMO only). Section [38.2-5805 C 9](#) of the Code states that the "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. The health carrier may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to the covered persons. Section [38.2-5805 C 10](#) of the Code states that if there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization.

ETHICS AND FAIRNESS

Failure of provider contracts to contain specific provisions and failure to adhere to the minimum standards in claims handling. Section [38.2-3407.15 B](#) of the Code requires that every provider contract entered into, amended, extended or renewed on or after July 1, 1999, shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services.

Section [38.2-3407.15](#) of the Code was effective July 1, 1999 and is applicable to contracts entered into, amended, extended or renewed on or after that date, originally requiring each provider contract to contain and comply with 9 specific provisions. This Code Section was amended in 2004 and 2005, adding additional provisions and modifying the language and requirements of the existing provisions. The current version of § [38.2-3407.15](#) of the Code is applicable to contracts entered into, amended, extended or renewed on or after January 1, 2006 and requires each provider contract to contain and comply with 11 specific provisions.

ADVERTISING/MARKETING COMMUNICATIONS

(Life & Annuity and Accident & Sickness)

Failure to maintain advertising file. [14 VAC 5-40-60 B](#) and [14 VAC 5-90-170 A](#) require each insurer to maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement with a notation attached indicating the manner and extent of distribution and the form number of any policy advertised. It is the opinion of the examiners that the “manner and extent of distribution” should include an indication of when the use of the advertisement began, the method of distribution, when it was discontinued, the number of advertisements disseminated, and the intended audience.

Every carrier shall maintain control over the method of dissemination, content, and form of all advertisements/marketing communications regardless of by whom written, created, designed, or presented, as required by [14 VAC 5-40-60 A](#) and [14 VAC 5-90-20 B](#).

Note: When violations of [Chapter 40](#) and [Chapter 90](#) of the Virginia Administrative Code are cited, it does not necessarily mean that the advertisement/marketing communication has actually misled or deceived any individual to whom it was presented. An advertisement/marketing communication may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement/marketing communication has the capacity or tendency to mislead or deceive from the overall impression that the advertisement/marketing communication may be reasonably expected to create within the segment of the public to which it is directed and, for marketing communications, the overall impression that the marketing communication may be reasonably expected to create upon a person of average education or intelligence within such segment of the public.

Failure to comply with specific requirements.

(Life and Annuity)

[14 VAC 5-40-40 A 5](#) requires a marketing communication using the terms “Non-medical,” “No medical examination required,” or similar terms where issuance of a policy is not guaranteed, to include a disclosure of equal prominence and in juxtaposition thereto that issuance of the policy may depend upon answers to health questions.

[14 VAC 5-40-40 E 2](#) prohibits a marketing communication of a particular policy from using the phrase “low cost” or any similar term unless such is capable of being demonstrated to the satisfaction of the Commission.

(Accident and Sickness)

Note: Effective August 4, 2004, 14 VAC 5-90-10 et seq. was amended to include definitions of an “invitation to contract” and an “invitation to inquire.” Certain regulations apply only to one or the other. The definitions are as follows:

“Invitation to contract” – an advertisement that includes in any manner an application for insurance.

“Invitation to inquire” – an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable and does not contain an application for coverage, but may include (i) the dollar amount of benefits payable, and (ii) the period of time during which benefits are payable. An invitation to inquire may not refer to cost, except as otherwise permitted by this chapter.

Note: For all definitions, please refer to [14 VAC 5-90-30](#).

[14 VAC 5-90-50 A](#) requires that the format and content of an advertisement be sufficiently complete and clear to avoid the capacity or tendency to mislead or deceive.

[14 VAC 5-90-60 A 1](#) prohibits the omission of or use of information, words, or phrases, if such omission or use would have the capacity or tendency to mislead as to the nature or extent of any policy benefit payable, loss covered, or premium payable.

[14 VAC 5-90-60 B 1](#) states that an invitation to contract shall disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy.

[14 VAC 5-90-130 A](#) states that the name of the actual insurer and the form number or numbers of the policies being advertised and the form number of any application shall be stated on all invitations to contract. An invitation to contract shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

Violations of the regulations above also place insurers in violation of §§ [38.2-502](#), [38.2-503](#), and [38.2-4312 A](#) of the Code, which prohibit a company from placing before the public an advertisement, statement, presentation or representation relating to policy benefits or the business of insurance that is deemed to be untrue, deceptive, or misleading.

POLICY AND OTHER FORMS

Failure to file and receive approval of policy forms prior to use. [Subsections A, B, and C of § 38.2-316 of the Code](#), [14 VAC 5-100-50](#), and [14 VAC 5-211-60 A](#) set forth filing and approval requirements for policy/contract forms, certificates, applications, evidences of coverage, riders, amendments, endorsements, and other forms that are to be delivered or issued for delivery within this Commonwealth in addition to approval requirements for certain premium rate changes.

Note: [14 VAC 5-100-50 3](#) requires a form to be submitted in the final form in which it is to be marketed or issued, and [14 VAC 5-100-40 2](#) states that where forms are submitted as replacements, revisions or modifications of previously approved forms, such must be clearly indicated in the letter of transmittal which shall set forth the exact changes that are intended.

Note: Section [38.2-3725 A](#) of the Code, which also sets forth requirements for policy forms, is addressed in the Credit Life and Credit Accident & Sickness Insurance section of this document.

Failure to file Explanation of Benefits (EOB) forms. Section [38.2-3407.4 A](#) of the Code requires each company issuing accident and sickness coverage to file its EOBs with the Commission for approval. These forms are subject to the requirements of § [38.2-316](#) or § [38.2-4306](#) of the Code, as applicable.

Failure to track and send proper notice of copayment maximums (HMO only). [14 VAC 5-211-90 B](#) sets forth the maintenance and notification requirements in cases where an HMO has established a copayment maximum. The HMO must keep accurate records of each enrollee's copayment expenses and notify the enrollee within 30 days after the HMO has processed sufficient claims to determine that the copay maximum is reached. No additional copayments will be charged for the balance of the contract or calendar year, and the HMO shall promptly refund to the enrollee any copayments charged after this maximum is reached. The evidence of coverage must display any maximum copayment amount as a specified dollar amount and clearly state the HMO's procedure for meeting the requirements of this subsection.

AGENTS

Failure to license and appoint agents. Section [38.2-1822 A](#) of the Code requires a person to be licensed prior to selling, soliciting, or negotiating contracts or receiving any commission from the sale, solicitation, or negotiation of any such contract. Section [38.2-1833 A 1](#) of the Code requires a company to, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

Note: Section [38.2-3734](#) of the Code, which also sets forth license requirements, is addressed in the Credit Life and Credit Accident & Sickness Insurance section of this document.

Payment of commissions to agents who are not licensed or appointed. Section [38.2-1812 A](#) of the Code prohibits the payment of commissions or other valuable consideration to an agent or agency that is not appointed and that was not licensed at the time of the transaction out of which arose the right to such commission or other valuable consideration.

Failure to notify agent/Commission of appointment termination. Section [38.2-1834 D](#) of the Code requires that an agent be notified within 5 days and the Commission within 30 days upon termination of an appointment.

UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT/INSURANCE REPLACEMENT

Failure to provide required Disclosure Authorization Form. [Subsection 8 of § 38.2-606](#) of the Code requires all disclosure authorization forms to advise that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form.

Failure to provide required Adverse Underwriting Decision (AUD) Notice. Section [38.2-610](#) of the Code requires that, in the event of an adverse underwriting decision, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission. Section [38.2-610 A 2](#) of the Code requires the AUD notice to provide the applicant with a summary of the rights established under §§ [38.2-610 B](#), [38.2-608](#) and [38.2-609](#) of the Code.

Note: For further guidance as to what constitutes an Adverse Underwriting Decision under Virginia Law, please refer to [Administrative Letter 2003-6](#). To review a prototype AUD Notice, please refer to [Administrative Letter 1981-15](#).

COMPLAINTS

Failure to maintain a complete record of complaints. Section [38.2-511](#) of the Code requires that a complete record of complaints be maintained for all complaints that the carrier has received since the date of the carrier's last examination. All health carriers subject to Chapter 58 of this title must maintain a record of the complaints for no less than five years. The record shall indicate the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint.

CLAIMS

Failure to acknowledge and act reasonably promptly upon communications with respect to claims. Section [38.2-510 A 2](#) of the Code prohibits, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. [14 VAC 5-400-50 A](#) (if applicable) states that every insurer, upon receiving notification of a claim shall, within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given by a claimant to an agent of an insurer shall be notification to the insurer.

Failure to adopt and implement reasonable standards for the prompt investigation of claims. Section [38.2-510 A 3](#) of the Code prohibits, as a general business practice, failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. [14 VAC 5-400-60 B](#) (if applicable) states that, unless otherwise specified in the policy, if an investigation of a first party claim has not been completed, every insurer shall, within 45 days from the date of the notification of a first party claim and every 45 days thereafter, send to the first party claimant a letter setting forth the reasons additional time is needed for investigation.

Failure to affirm or deny a claim within a reasonable period of time. Section [38.2-510 A 5](#) of the Code prohibits, as a general business practice, the failure to affirm or deny claims within a reasonable time after proof of loss statements have been completed. [14 VAC 5-400-60 A](#) (if applicable) requires that, unless otherwise stated in the policy, within 15 working days after receipt by the company of properly executed proofs of loss, a first party claimant shall be advised of the acceptance or denial of the claim by the company.

Failure to attempt in good faith to make prompt, fair and equitable settlements of claims. Section [38.2-510 A 6](#) of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. [14 VAC 5-400-70 D](#) (if applicable) states that, in any case where there is no dispute as to coverage or liability, every insurer must offer to a first party claimant, or to a first party claimant's authorized representative, an amount which is fair and reasonable as shown by the investigation of the claim, provided the amount so offered is within policy limits and in accordance with policy provisions.

Failure to promptly provide a reasonable explanation of the basis in the insurance policy for denial of a claim. Section [38.2-510 A 14](#) of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. [14 VAC 5-400-70 B](#) (if applicable) states that no insurer shall deny a claim unless a reasonable explanation of the basis for such denial is included in the written denial. Specific reference to a policy provision, condition or exclusion shall be made when a denial is based on such provision, condition or exclusion.

Failure to disclose the method of benefit calculation and actual amount paid to the provider on the EOB. Section [38.2-514 B](#) of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or HMO contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services.

Failure to accurately set forth the benefits payable on the EOB. Section [38.2-3407.4 B](#) of the Code requires an explanation of benefits to accurately and clearly set forth the benefits payable under the contract.

Failure to pay interest on claim proceeds as required. Section [38.2-3115 B](#) of the Code (life insurance and annuity only) states that interest upon the principal sum shall be paid at an annual rate of 2-1/2 percent or the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater, commencing from the date of death to the date of payment. Section [38.2-3407.1 B](#) of the Code (accident and sickness insurance only) requires interest to be paid on claims from the date of 15 working days after the receipt of proof of loss. Section [38.2-4306.1 B](#) of the Code (HMO only) sets forth the requirement for payment of interest on claim proceeds from the date of 30 days from the date the proof of loss is received to the date of claim payment.

Holding an enrollee liable for the cost of covered services prior to a Coordination of Benefits determination (HMO only). [14 VAC 5-211-80 B](#) states that a health care plan shall not be relieved of its duty to provide a covered health care service to an enrollee because the enrollee is entitled to coverage under other policies, contracts, or health care plans. In the event that benefits are provided by a health care plan and another policy, contract, or health care plan, the determination of the order of benefits shall in no way restrict or impede the rendering of services required to be provided by the health care plan. The HMO shall be required to provide or arrange for the service first and then, at its option, seek coordination of benefits with any other health insurance or health care benefits or services that are provided by other group policies, group contracts, or group plans. Until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided.

CREDIT LIFE AND CREDIT ACCIDENT & SICKNESS INSURANCE

As a result of target market conduct examinations of insurers licensed in Virginia to write Credit Life Insurance and/or Credit Accident and Sickness Insurance, the Bureau of Insurance discovered widespread violations of the statutory requirements in Chapter 37.1 of the Code of Virginia. This section has been added to the Common Problems publication to point out areas in which compliance problems were frequently found.

Inappropriate issuance of credit insurance based on the scope under Chapter 37.1 of the Code. [Subsection 1 of § 38.2-3717](#) of the Code prohibits the issuance of credit insurance in connection with a loan or other credit transaction of more than ten years duration. [Subsection 2 of § 38.2-3717](#) of the Code prohibits the issuance of credit insurance in connection with a loan or other credit transaction that is secured by a first deed of trust and made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for such a purpose.

Failure to file and receive approval of policy forms prior to use. Section [38.2-3725 A](#) of the Code states that no form shall be delivered or issued for delivery in Virginia until a copy of each form has been filed with and approved by the Commission.

Failure to provide prompt and appropriate refunds in the event of early termination. Section [38.2-3729 A](#) of the Code requires that, in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance must be paid or credited promptly to the person entitled thereto. Sections [38.2-3729 H 1](#) and [38.2-3729 H 2](#) of the Code require an insurer to provide the appropriate credit life and credit accident and sickness insurance premium refunds in the event that a debtor prepaies the indebtedness other than as a result of death.

Failure to properly handle claims. Section [38.2-3731 A](#) of the Code requires that claims be reported promptly to the insurer; that the insurer maintain adequate claim files; and that all claims be settled as soon as possible and in accordance with the terms of the insurance contract.

Failure to oversee activities delegated to creditors. [Subsections 1 and 2 of § 38.2-3732](#) of the Code require any insurer that delegates any of its duties to a creditor to see that the creditor charges the proper insurance rates and makes refunds properly. If either the insurer or the creditor fails to comply, both will be subject to any and all disciplinary actions authorized under this title.

Note: As outlined in [Administrative Letter 2004-2](#), insurers are reminded that it is their responsibility to ensure that all duties delegated to a creditor are discharged in accordance with applicable laws and regulations. The Bureau will hold the insurer responsible and accountable for any failures, oversights, omissions or violations committed by the creditor conducting business on behalf of the insurer.

Failure to license and appoint agents. Section [38.2-3734](#) of the Code prohibits any person from selling, soliciting, or negotiating policies of credit life insurance or credit accident and sickness insurance without first applying for and obtaining a license from the Commission as a life and annuities insurance agent, a health agent, or a limited lines credit insurance agent and becoming appointed to represent the insurer in the Commonwealth.

Note: As stated in [Administrative Letter 2002-9](#), any person or entity that sells, solicits, or negotiates contracts of insurance or annuity in Virginia on behalf of an insurer is required to hold a valid insurance agent's license in Virginia. Any entity, be it insurer, agency or agent, that receives a commission from an insurer, directly or indirectly (whether characterized as an "override," "fee," or otherwise) arising from the sale of a contract of insurance or annuity, even if there was no active "selling, soliciting, or negotiating" by that entity, must be licensed and appointed in Virginia. If a store, bank or dealership provides its customers with the opportunity to purchase credit insurance and is paid a commission, it would need to be licensed as an agency. Please refer to [Administrative Letter 2002-9](#) for further clarification including the Bureau's position regarding "enrollers."

Failure to provide proper disclosures. Section [38.2-3735 A](#) of the Code requires that if the creditor makes available to the debtors more than one plan of credit life insurance or more than one plan of credit accident and sickness insurance, all debtors must be informed of all such plans for which they are eligible; section [38.2-3735 A 2](#) of the Code requires the creditor to

provide to each debtor a disclosure form which clearly discloses the difference in premiums charged for a contract wherein the gross indebtedness is insured versus a contract wherein only the net indebtedness is insured; and section [38.2-3735 C 2](#) of the Code requires that the debtor be given a disclosure form which clearly discloses the difference in premiums charged for a contract with credit insurance and one without credit insurance.

Failure to file application for approval. Section [38.2-3737 A](#) of the Code states that no contract of insurance upon a debtor shall be made or effectuated unless at the time of the contract, the debtor applies for the insurance in writing on a form approved by the Commission.

EXAMINATIONS

Examinations; how conducted. Section [38.2-1318 C](#) of the Code requires that every company or person from whom information is sought, its officers, directors, and agents shall provide the examiners convenient access at all reasonable hours to its books, records, files, securities, accounts, papers, property, assets, business and affairs of the company being examined or those of any person, including any affiliates or subsidiaries of the person examined, that are relevant to the examination.