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HOUSE BILL NO. 2121

Offered January 10, 2007

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A BILL to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 63, consisting of sections numbered 38.2-6300 through 38.2-6314, relating to the Health Insurance Exchange Act.

Patron—Marshall, R.G.

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 38.2 a chapter numbered 63, consisting of sections numbered 38.2-6300 through 38.2-6314, as follows:

CHAPTER 63.

HEALTH INSURANCE EXCHANGE ACT.

§ 38.2-6300.

As used in this chapter, unless the context requires a different meaning:

"Applicant" means an individual seeking to participate in the Virginia Health Insurance Exchange.

"Carrier" means any person or organization subject to the authority of the Commissioner that provides one or more health benefit plans or insurance in Virginia and includes an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, or a multiple employer welfare arrangement.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, approved April 7, 1986 (100 Stat. 231; 29 U.S.C. § 1161 et seq.).

"Creditable coverage" means continual coverage of the applicant under any of the following health plans, with no lapse in coverage of more than 63 days immediately prior to the date of application:

1. A group health plan;

2. Health insurance coverage;

3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);

4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under 42 U.S.C. § 1928;

5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

9. A public health plan (as defined in federal regulations);

10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)); or

11. Any other qualifying coverage required by HIPAA as it may be amended or regulations promulgated under HIPAA.

Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

"Dependent" means (i) the spouse of the principal insured or (ii) an individual who is related to the principal insured by birth, marriage, or adoption. The term also includes an individual who also meets the definition of a dependent as set forth in the United States Internal Revenue Code, 26 USC § 152.

"Eligible individual" means an individual who is eligible to participate in the Virginia Health Insurance Exchange by reason of meeting one or more of the following qualifications:

1. The individual is a resident of the Commonwealth, meaning that the individual is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in Virginia that remains the person's principal residence and from which the person is absent only for temporary or transitory purpose. A person who is a full-time student attending an institution outside of the Commonwealth may maintain his Virginia residency.

2. The individual is not a resident of the Commonwealth but is employed at least 20 hours a week on a regular basis at a Virginia location by a bona fide employer, and the individual's employer does not offer a group health insurance plan, or the individual is not eligible to participate in any group health insurance plan offered by his employer;

3. The individual, whether a resident or not, is enrolled in or eligible to enroll in a participating employer plan.

4. The individual is self-employed in the Commonwealth and, if he is a nonresident self-employed individual, his principal place of business is in the Commonwealth.

5. The individual is a full-time student attending an institution of higher education located in the

Commonwealth.

6. The individual, whether a resident or not, is a dependent of another individual who is an eligible individual.

"Employer" means an individual, partnership, association, corporation, legal representative, receiver, trustee, or trustee in bankruptcy doing business in or operating within the Commonwealth that employs another to work for wages, salaries, or on commission and shall include any similar entity acting directly or indirectly in the interest of an employer in relation to an employee.

"Excepted benefits" means any one or more, or any combination, of the following:

1. The following benefits that are not subject to the requirements of this chapter:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

2. The following benefits that are not subject to the requirements of this chapter if offered separately:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

c. Such other similar, limited benefits as are specified in regulations;

3. The following benefits that are not subject to the requirements of this chapter if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance; and

4. The following benefits that are not subject to the requirements of this chapter if offered as a separate insurance policy:

a. Medicare supplemental health insurance as defined under section 1882 (g)(1) of the Social Security Act, approved June 9, 1980, 72 Stat. 1445, 42 U.S.C. § 1395ss(g)(1);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

c. Similar supplemental coverage provided to coverage under a group plan.

"Exchange" means the Virginia Health Insurance Exchange established by this chapter.

"Federal health coverage tax credit eligible individual" means any individual who is eligible for benefits under section 201 of the Trade Act of 2002, approved August 6, 2002 (116 Stat. 933; 26 USC § 35(c) (2003)), as amended.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (Pub. L. 104-191; 110 Stat. 1136).

"Participating employer plan" means a group health plan, as defined in federal law (§ 706 of ERISA (29 USC § 1186)), that is sponsored by an employer and for which the plan sponsor has entered into an agreement with the Exchange, in accordance with the provisions of this chapter, for the Exchange to offer and administer health insurance benefits for enrollees in the plan.

"Participating individual" means a person who has been determined by the Exchange to be and continues to remain an eligible individual for purposes of obtaining coverage under participating insurance plans offered through the Exchange.

"Participating insurance plan" means a health benefit plan offered through the Exchange.

"Plan year" means the period of time during which the insured is covered under a health benefit plan, as stipulated in the contract governing the plan.

"Preexisting conditions provision" means a provision in a health benefit plan that limits, denies, or excludes benefits for a period of time for an enrollee for expenses or services related to a medical condition that was present before the date the coverage commenced, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. The time period for a preexisting conditions provision begins when an application for insurance is made or when an applicant is in a waiting period for coverage under any plan. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

"Producer" means a person required to be licensed in the Commonwealth to sell, solicit, or negotiate insurance.

"Rate" means the premiums or fees charged by a health benefit plan for coverage under the plan.

"Self-funded health benefit plan" means a health insurance plan, not subject to regulation by the

Commonwealth or any other state, that is paid in whole or in part by the employer from its own assets or from a funded welfare benefit plan, provided that such plan does not shift any risk or liability for benefit payments to an insurer or other carrier other than through reinsurance or stop-loss coverage.

§ 38.2-6301. Virginia Health Insurance Exchange; creation; purpose.

A. There is created a nonprofit legal entity to be known as the Virginia Health Insurance Exchange. The Exchange is created to effectuate public purposes provided for in this chapter but with a legal existence separate from that of the Commonwealth. The Exchange shall seek recognition as a not-for-profit corporation by the United States in accordance with the provisions of the United States Internal Revenue Code, 26 USC § 501(c).

B. The Exchange is created for the limited purpose of providing the residents of the Commonwealth, and such other individuals as may from time to time also be eligible to participate, with greater access to and choice and portability of health insurance products.

C. The Exchange shall operate in accordance with all requirements and restrictions set forth in this chapter and all other applicable laws of the Commonwealth and of the United States.

D. All eligible individuals shall be permitted to obtain health insurance benefits through the Exchange, subject to the provisions of this chapter.

E. The Exchange shall exercise its powers through a board of directors established under § 38.2-6302.

§ 38.2-6302. Board of directors; Exchange director.

A. The Exchange shall be governed by a board of directors consisting of the Commissioner and 12 members to be appointed by the Commission. In approving selections or in appointing members to the board the Commission shall consider, among other things, whether all domestic and foreign member insurers are fairly represented. Four of the 12 directors initially shall be appointed for terms of two and one-half years, four for terms of four and one-half years, and four for terms of six and one-half years from the effective date of their appointment; thereafter the terms of members of the Board shall be six years. No member shall be eligible to serve more than two terms; however, after the expiration of the term of a member appointed to serve three years or less, two additional terms may be served if he is appointed thereto. Any appointment to fill a vacancy shall be for the unexpired term. A person appointed to fill a vacancy may be appointed to serve two additional terms. Members of the Board shall receive their expenses and shall be compensated at the rate provided in § 2.2-2104 for each day spent on the business of the Board.

B. The Board shall elect from its membership a chairman and a vice-chairman and shall also elect a secretary and a treasurer, who need not be members of the Board, and may also elect other subordinate officers, who need not be members of the Board. The Board may also form committees and advisory councils, which may include representatives who are not members of the Board, to undertake more extensive study and discussion of the issues before the Board.

C. A majority of the Board shall constitute a quorum for the transaction of the Exchange's business, and no vacancy in the membership shall impair the right of a quorum to exercise the rights and perform all duties of the Exchange.

D. The Board shall appoint an Exchange Director, who shall not be a member of the Board, who shall be a full-time employee of the Exchange, administer all of the Exchange's activities and contracts, supervise the staff of the Exchange, and carry out the powers and duties conferred upon him by the Board. The Exchange Director shall serve at the pleasure of the Board.

§ 38.2-6303. Responsibilities of Exchange.

The Exchange shall:

1. Publicize the existence of the Exchange and disseminate information on eligibility requirements and enrollment procedures for the Exchange.

2. Establish and administer procedures for enrolling eligible individuals in the Exchange, including:

a. Creating a standard application form to collect information necessary to determine an applicant's eligibility and coverage history; and

b. Preparing and distributing certificate of eligibility forms and application forms to insurance producers and the general public.

3. Establish and administer procedures, in accordance with § 38.2-6305, for the election of coverage by participating individuals during open season periods and outside of open season periods upon the occurrence of any qualifying event specified in subsection D of § 38.2-6305, including preparing and distributing to participating individuals:

a. Descriptions of the coverage, benefits, limitations, copayments, and premiums for all participating plans; and

b. Forms and instructions for electing coverage and arranging payment for coverage.

4. Collect and transmit to the applicable participating plans all premium payments or contributions made by or on behalf of participating individuals, including developing mechanisms to:

a. Receive and process automatic payroll deductions for participating individuals enrolled in participating employer plans;

b. Enable participating individuals to pay, in whole or part, for coverage through the Exchange by electing to assign to the Exchange any federal Earned Income Tax Credit payments due the participating individual; and

c. Receive and process any federal or state tax credits or other premium support payments for health insurance, as may be established by law.

5. Upon request, issue certificates of previous coverage in accordance with the provisions of HIPAA to all such individuals who cease to be covered by a participating insurance plan.

6. Establish procedures to account for all funds received and disbursed by the Exchange, including:

a. Maintaining a separate, segregated Management Account for the receipt and disbursement of moneys allocated to fund the administration of the Exchange; and

b. Maintaining a separate, segregated Operations Account for:

(1) The receipt of all premium payments or contributions made by or on behalf of participating individuals; and

(2) The distribution of premium payments to participating plans and of commissions or payments to licensed insurance producers and such other organizations as are permitted under § 38.2-6311 to receive payments for their services in enrolling eligible individuals or groups in the Exchange.

7. Submit to the Commissioner, following the end of each plan year, the report of an independent audit of the Exchange's accounts for the plan year.

§ 38.2-6304. Powers.

The Exchange shall have the power to:

1. Contract with vendors to perform one or more of the functions specified in § 38.2-6303.

2. Contract with private or public social service agencies to administer application, eligibility verification, enrollment, and premium payments for specified groups or populations of eligible individuals or participating individuals.

3. Contract with employers to act as the plan administrator for participating employer plans, subject to the provisions of § 38.2-6310, and to undertake the obligations required by federal law of a plan administrator.

4. Set and collect fees from participating individuals, participating employer plans, and participating insurance plans sufficient to fund the cost of administering the Exchange.

5. Seek and directly receive grant funding from the United States Government, departments or agencies of the Commonwealth, local governments, or private philanthropic organizations to defray the costs of operating the Exchange.

6. Establish and administer rules and procedures governing the operations of the Exchange.

7. Establish one or more service centers within Virginia to facilitate enrollment.

8. Sue and be sued or otherwise take any necessary or proper legal action.

9. Establish bank accounts and borrow money.

§ 38.2-6305. Enrollment and coverage election.

A. Any eligible individual may apply to participate in the Exchange. An employer, a labor union, or an educational, professional, civic, trade, church, or social organization that has eligible individuals as employees or members may apply on behalf of those eligible persons. Upon determination by the Exchange that an individual is eligible in accordance with the provisions of this Act to participate in the Exchange, he may enroll or, when applicable, be enrolled by his parent or legal guardian in a participating insurance plan offered through the Exchange during the next open season period or, when applicable, at such other times as are specified in subsection D.

B. From November 1 to November 30 of each year, the Exchange shall administer an open season during which any eligible individual may enroll in any health benefit plan offered through the Exchange, subject to the provisions of § 38.2-6307, without a waiting period, and may not be declined coverage.

C. The first 90 days after the Exchange begins to accept applications shall be considered the initial open season.

D. Subject to the provisions of § 38.2-6307, an eligible individual may enroll in a health benefit plan offered through the Exchange, without a waiting period, and not be declined coverage, at a time other than the annual open season for any of the following reasons, provided the individual does so within 63 days of the triggering event:

1. The individual loses coverage in an existing health insurance plan due to the death of a spouse, parent, or legal guardian.

2. The individual or a covered dependent loses coverage in an existing health insurance plan due to a change in the individual's employment status;

3. The individual or a covered dependent loses coverage in an existing health insurance plan because of a divorce, separation, or other change in familial status;

4. The individual loses coverage in an existing health insurance plan because he achieves an age at

which coverage lapses under that plan;

5. The individual or a covered dependent becomes newly eligible by becoming a resident of the Commonwealth or because the individual's place of employment has been changed to Virginia;

6. The individual becomes newly eligible by becoming the spouse or dependent, by reason of birth, adoption, court order, or a change in custody arrangement, of an eligible individual.

7. The individual becomes subject to a court order requiring him or her to provide health insurance coverage to certain dependents or enters into a new arrangement for the custody of dependents that requires the providing of health insurance for those dependents.

8. The individual loses coverage in a plan offered through the Exchange by reason of the plan's terminating participation in the Exchange prior to the end of the plan year.

§ 38.2-6306. Participation of plans in the Exchange.

A. No health benefit plan may be offered through the Exchange unless the Commissioner has first certified to the Exchange that:

1. The carrier seeking to offer the plan is licensed to issue health insurance in the Commonwealth and is in good standing with the Bureau of Insurance;

2. The plan meets the requirements of this chapter and the plan and the carrier are in compliance with all other applicable health insurance laws of the Commonwealth.

B. No plan shall be certified that excludes from coverage any individual otherwise determined by the Exchange as meeting the eligibility requirements for participating individuals.

C. The certification of plans to be offered through the Exchange shall not be subject to any law of the Commonwealth requiring competitive bidding;

D. Each certification shall be valid for a uniform term of at least one year but may be made automatically renewable from term to term in the absence of notice of either:

1. Withdrawal by the Commissioner; or

2. Discontinuation of participation in the exchange by the plan or carrier.

E. Certification of a plan may be withdrawn only after notice to the carrier and opportunity for hearing. The Commissioner may, however, decline to renew the certification of any carrier at the end of a certification term.

F. Each plan certified by the Commissioner as eligible to be offered through the Exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions, and other benefit limits.

G. Each plan certified by the Commissioner as eligible to be offered through the Exchange shall provide, subject to the plan's deductibles and coinsurance or copayment schedule, major medical coverage that includes the following:

1. Hospital benefits;

2. Surgical benefits;

3. In-hospital medical benefits;

4. Ambulatory patient benefits;

5. Prescription drug benefits; and

6. Mental health benefits.

H. Carriers shall offer plans in the Exchange at standard rates based on age, geography and family composition and that have been determined to be actuarially sound in the judgment of the Commissioner.

I. The rates determined for the first plan year for which the plan is offered through the Exchange may be adjusted by the carrier for subsequent plan years based on experience and any later modifications to plan benefits, provided that any adjustments in rates shall be made in advance of the plan year for which they will apply and on a basis that, in the judgment of the Commissioner, is consistent with the general practice of carriers that issue health benefit plans to large employers.

J. The Exchange shall not decline or refuse to offer, or otherwise restrict the offering to any participating individual, any plan that has obtained, in a timely fashion in advance of the annual open season, certification by the Commissioner in accordance with the provisions of this section.

K. The Exchange shall not sponsor any insurance or benefit plan or contract with any carrier to offer an insurance or benefit plan as a participating plan that has not first been certified by the Commissioner in accordance with the provisions of this section.

L. The Exchange shall not impose on any participating plan or on any carrier or plan seeking to participate in the Exchange any terms or conditions, including requirements or agreements with respect to rates or benefits, beyond or in addition to those terms and conditions established and imposed by the Commissioner in certifying plans under the provisions of this section.

M. The Commissioner shall establish and administer regulations and procedures for certifying plans to participate in the Exchange, in accordance with the provisions of this section.

§ 38.2-6307. Underwriting rules.

The following rules shall govern the imposition by carriers of any preexisting condition provisions and rating surcharges with respect to any participating individual covered by any participating insurance plan:

1. Except as otherwise specified in subdivisions 3 and 4, during any open season a participating individual who elects to choose a different participating insurance plan or plan option for the next plan year shall not be subject to any preexisting condition provisions and shall be charged the standard rate of the new participating insurance plan or plan option for persons of the participating individual's age and geographic area. The same shall apply to any election by a participating individual of coverage for any dependent who is also a participating individual.

2. A new participating individual with 18 months or more of creditable coverage who enrolls in a participating insurance plan shall not be subject to any preexisting condition provisions and shall be charged the applicable age and geography adjusted standard rate for the participating insurance plan.

3. A new participating individual with creditable coverage of between two and 17 months may enroll in a participating insurance plan, but the participating individual may be subject to one or more preexisting condition provisions for a period not to exceed 12 months, the number of such months to be reduced by the number of months of creditable coverage, or charged a premium not to exceed 125% of the otherwise applicable age and geography adjusted standard rate for the participating insurance plan, or both. Any such rate surcharge shall not be applied during the third or subsequent years of the individual's enrollment in any participating insurance plan.

4. A new participating individual with two months or less of creditable coverage may enroll in a participating insurance plan, but the participating individual may be subject to one or more preexisting condition provisions, for a period not to exceed 12 months, the number of such months to be reduced by the number of months of creditable coverage, or charged a premium not to exceed 150% of the otherwise applicable age and geography adjusted standard rate for the participating insurance plan, or both. Any such rate surcharge shall not be applied during the third or subsequent years of the individual's enrollment in any participating insurance plan.

5. In cases where an individual is enrolled in a plan offered through the Exchange as a newly eligible dependent of an participating individual, by reason of birth, adoption, court order, or change in custody arrangement, either during open season or outside of open season in accordance with subdivision D 6 of § 38.2-6305, a carrier shall not impose any preexisting condition provisions or any change in the rate charged to the participating individual except for such difference, if any, in the participating insurance plan's standard rates that reflect the addition of a new dependent to the participating individual's coverage.

6. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications or in such other manner as may be specified in federal law or any other provision of this title.

7. For new participating individuals without creditable coverage, or with only limited creditable coverage as defined in subdivisions 3 and 4 of this section, a carrier may elect to waive the imposition of preexisting condition provisions and instead extend the applicable rate surcharge for an additional year beyond the time provided for in those subsections.

8. For purposes of this section, any individual who is a participating individual by reason of enrollment in a participating employer plan shall be deemed to have 18 months of creditable coverage.

9. For purposes of this section, any federal health coverage tax credit eligible individual shall be deemed to have 18 months of creditable coverage.

§ 38.2-6308. Continuation of coverage.

A. Any participating individual may continue to participate in any participating insurance plan as long as the individual remains an eligible individual, subject to the carrier's rules regarding cancellation for nonpayment of premiums or fraud and shall not be cancelled or nonrenewed because of any change in employer or employment status, marital status, health status, age, membership in any organization, or other change that does not affect eligibility as defined in this chapter.

B. A participating individual who is not a resident of the Commonwealth and who ceases to be an eligible individual due to a qualifying event shall be deemed to remain an eligible individual and shall be deemed to remain a participating individual for a period not to exceed 36 months from the date of the qualifying event, if:

1. The qualifying event consists of a loss of eligible individual status due to:

a. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or

b. Loss of qualified dependent status for any reason; and

2. The participating individual elects to remain a participating individual and notifies the Exchange of such election within 63 days of the qualifying event.

§ 38.2-6309. Dispute resolution.

A. The Commissioner shall establish procedures for resolving disputes arising from the operation of the Exchange in accordance with the provisions of this chapter, including disputes with respect to:

1. The eligibility of an individual to participate in the Exchange;

2. The imposition of a coverage surcharge on a participating individual by a participating plan; and

3. The imposition of a preexisting condition provision on a participating individual by a participating plan.

B. In cases where a carrier, in accordance with the provisions of this section, imposes a preexisting condition exclusion or a premium surcharge in connection with the enrollment of a participating individual in a participating insurance plan offered by the carrier and the participating individual disputes the imposition of such an exclusion or surcharge, the participating individual may request that the Commissioner issue a determination as to the validity or extent of such exclusion or surcharge under the provisions of this chapter. The Commissioner or his designee shall issue such a determination within 30 days of the request being filed with the Commission. If either the participating individual or the carrier disagrees with the outcome, he or she may submit a request for a hearing to the Commissioner in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq.).

§ 38.2-6310. Participating employer plans.

A. Any employer may apply to the exchange to be the sponsor of a participating employer plan.

B. Any employer seeking to be the sponsor of a participating employer plan shall, as a condition of participation in the Exchange, enter into a binding agreement with the Exchange, which shall include the following conditions:

1. The sponsoring employer designates the Exchange Director to be the plan's administrator for the employer's group health plan, and the Exchange Director agrees to undertake the obligations required of a plan administrator under federal law;

2. Only the coverage and benefits offered by participating insurance plans shall constitute the coverage and benefits of the participating employer plan;

3. Any individuals eligible to participate in the Exchange by reason of their eligibility for coverage under the employer's participating employer plan, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan, may elect coverage under any participating insurance plan, and neither the employer nor the Exchange shall limit such individuals choice of coverage from among all the participating insurance plans.

4. The employer reserves the right to offer benefits supplemental to the benefits offered through the Exchange, but, under federal law, any supplemental benefits offered by the employer shall constitute a separate plan or plans, for which the Exchange Director shall not be the plan administrator and for which neither the Exchange Director nor the Exchange shall be responsible in any manner;

5. The employer agrees that for the term of the agreement the employer will not offer to individuals eligible to participate in the Exchange by reason of their eligibility for coverage under the employer's participating employer plan any separate or competing group health plan offering the same or substantially similar benefits as those provided by participating insurance plans through the Exchange, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan;

6. The employer reserves the right to determine the criteria for eligibility, enrollment, and participation in the participating employer plan and the terms and amounts of the employer's contributions to that plan, so long as for the term of the agreement with the Exchange the employer agrees not to alter or amend any criteria or contribution amounts at any time other than during an annual period designated by the Exchange for participating employer plans to make such changes in conjunction with the Exchange's annual open season;

7. The employer agrees to make available to the Exchange any of the employer's documents, records, or information, including copies of the employer's federal and state tax and wage reports, that the Commissioner reasonably determines are necessary for the Exchange to verify:

a. That the employer is in compliance with the terms of its agreement with the Exchange governing the employer's sponsorship of a participating employer plan;

b. That the participating employer plan is compliance with applicable laws relating to employee welfare benefit plans, particularly those relating to nondiscrimination in coverage; and

c. The eligibility, under the terms of the employer's plan, of those individuals enrolled in the participating employer plan.

8. The employer agrees to also sponsor a cafeteria plan as permitted under 26 U.S.C. § 125 for all employees eligible for coverage under the employer's participating employer plan.

C. The Exchange may not enter into any agreement with any employer with respect to any employer participating plan if such agreement does not, at a minimum, incorporate the conditions specified in subsection B.

D. The Exchange may not enter into any agreement with any employer with respect to any participating employer plan for the Exchange to provide the participating employer plan with any additional or different services or benefits not otherwise provided or offered to all other participating

employer plans.

E. Beginning with the first plan year following the establishment of the Exchange, the Commonwealth shall enter into an agreement with the Exchange to be the sponsor of a participating employer plan on behalf of any individual eligible for health insurance benefits paid in whole or in part by the Commonwealth by reason of current or past employment by the Commonwealth, or by reason of being a dependent of such an individual, excepting such individuals eligible for benefits consisting solely of coverage of excepted benefits.

§ 38.2-6311. Insurance producers.

A. In cases when a producer licensed in the Commonwealth enrolls in the Exchange an eligible individual or group, the plan chosen by each individual shall pay the producer a commission in an amount that the Commissioner shall determine is reasonable, based on commissions that are paid in the relevant market and such other factors as the Commissioner deems relevant.

B. If a membership organization enrolls in the Exchange, the plan chosen by each eligible member or the eligible members of its member entities shall pay the organization a fee equal to the commission specified in subsection A. Nothing in this section shall be deemed either to require a membership organization that enrolls persons in the Exchange to be licensed by the Commission as an insurance producer or to permit such an organization to provide any other services requiring licensure as an insurance producer without first obtaining such license.

§ 38.2-6312. Statement of coverage form.

A. Each employer in the Commonwealth shall annually file with the Commissioner a form for each employee employed within Virginia indicating the health insurance coverage status of the employee and the employee's dependents, including the source of coverage and the name of the insurer or plan sponsor and, if no coverage is indicated:

1. The employee's election, in lieu of insurance coverage, to post a bond or to establish an account in accordance with § 38.2-6314;

2. The employee's election to apply or not to apply for coverage through the Exchange; and

3. The employee's election to be considered, or not to be considered, for any publicly financed health insurance program or premium subsidy program administered by the Commonwealth.

B. Each form shall be signed by the individual to whom it pertains.

C. Each self-employed individual in the Commonwealth shall annually file the form required by this section with the Commissioner.

D. The Director of the Department of Medical Assistance Services shall annually file the same form with the Commissioner on behalf of all individuals receiving benefits under the State Plan for Medicaid Services adopted pursuant to § 32.1-325 et seq., the State Children's Health Insurance Plan pursuant to Title XXI of the United States Social Security Act, or other state coverage program, excepting such individuals as who are also covered by Part A or Part B of Title XVIII of the Social Security Act (79 Stat. 291; 42 U.S.C. § 1395c et seq. or 1395j et seq., respectively);

E. For purposes of this section, health insurance coverage shall not include any coverage consisting solely of one or more excepted benefits.

F. The Commissioner shall prepare and distribute such forms.

§ 38.2-6313. Insurance market consolidation.

A. A carrier shall not issue or renew an individual health benefit plan, other than through the Exchange established under § 38.2-6301, after the first day of the plan year following the first regular open season conducted by the Exchange in accordance with § 38.2-6305.

B. A carrier shall not issue or renew a group health benefit plan to a small employer with 50 or fewer employees, other than through the Exchange established under § 38.2-6301, after the first day of the plan year following the first regular open season conducted by the Exchange in accordance with § 38.2-6305.

C. Subsections A and B shall not apply to any health benefit plan that consists solely of one or more excepted benefits.

§ 38.3-6314. Personal responsibility.

A. Effective January 1, 2009, individuals who reside in the Commonwealth who are over the age of 18 and have not yet attained the age of 65 shall offer proof of their ability to pay for medical care for themselves and their dependents; however, individuals who become residents of the Commonwealth after that date shall offer proof of their ability to pay for medical care for themselves and their dependents within 63 days of establishing residency.

B. Individuals subject to the requirement in subsection A shall be deemed to be in compliance with said requirement if they either indicated coverage under any health benefit plan in accordance with § 38.2-6312 or demonstrate proof of financial security in accordance with subsection C.

C. Pursuant to subdivision B 2, individuals electing to demonstrate proof of financial security to pay for medical expenditures shall present to the Secretary of Finance a bond in the amount of $10,000, or shall deposit with the Treasury Department $10,000 in an escrow account that shall bear interest at a

rate provided in § 6.1-330.53.

D. If in any calendar year an individual subject to the requirement in subsection A fails to comply with said requirement, the Secretary of Finance shall establish an escrow account in the name of said individual and shall do one or more of the following:

1. Shall retain and deposit in said account all such funds as may be owed to said individual by the Commonwealth, including but not limited to any overpayment by said individual of any taxes imposed by the Commonwealth; and

2. Shall obtain an order for the attachment of the wages of said individual to satisfy the requirements of this section.

E. With respect to any escrow account established in accordance with this section, either by reason of an individual making the election specified in subsection C or by reason of an individual being subject to subsection D:

1. The amount deposited, retained, or collected shall not exceed $10,000 in aggregate for any such individual;

2. Nothing in this section shall be construed to authorize the Secretary of Finance to retain any amount for such purposes that otherwise would be paid to a claimant agency or agencies of the Commonwealth for obligations which are being enforced pursuant to a plan described in § 454 of the Social Security Act which has been approved by the Secretary of Health and Human Services under Part D of Title IV (42 U.S.C. 651 et seq.) of the Social Security Act;

3. Monies held in escrow accordance with this section shall be disbursed by the Secretary of Finance only to pay for medical claims for healthcare services provided to the individual during the period when the individual was not in compliance with subsection A of this Section.

4. The Secretary of Finance shall close the account and remit the remaining funds, to the individual within six months of receiving notification that the individual has;

a. Elected to comply with the requirement in subsection A by submitting proof of insurance coverage in accordance with subdivision B 1; or;

b. Is no longer subject to subsection A by reason of no longer being a resident of the Commonwealth.

5. If the Secretary of Finance determines that an individual for whom an account has been established has not been a resident of the Commonwealth for a consecutive period of 36 months or more, the Secretary of Finance shall close the account and remit the remaining funds to the individual, or if the Secretary of Finance cannot locate the individual, shall dispose of the funds in accordance with the provisions of he Uniform Disposition of Unclaimed Property Act (§ 55-210.1 et seq.).

F. Any judgment payable by an individual to a hospital, physician or other health care provider for charges incurred during a period when the individual failed to comply with subsection A shall include an order permitting the attachment of the wages of such individual to satisfy such judgment.

2. That the provisions of this act shall become effective on January 1, 2008.