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**SENATE BILL NO. 578**

Offered January 9, 2008

Prefiled January 9, 2008

*A BILL to amend and reenact §§ 2.2-2101, as it exists and as it may become effective, and 38.2-3407.12 of the Code of Virginia, and to amend the Code of Virginia by adding in Title 32.1 a chapter numbered 16, consisting of sections numbered 32.1-368 through 32.1-377 and in Chapter 34 of Title 38.2 an article numbered 5.1, consisting of sections numbered 38.2-3438 through 38.2-3447, relating to the VirginiaShare Health Insurance Program.*

Patrons—Saslaw and Watkins

Referred to Committee on Commerce and Labor

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 2.2-2101, as it exists and as it may become effective, and 38.2-3407.12 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Title 32.1 a chapter numbered 16, consisting of sections numbered 32.1-368 through 32.1-377 and in Chapter 34 of Title 38.2 an article numbered 5.1, consisting of sections numbered 38.2-3438 through 38.2-3447 as follows:**

§ 2.2-2101. (Effective July 1, 2008, for contingent expiration date, see Editor's note) Prohibition against service by legislators on boards, commissions, and councils within the executive branch; exceptions.

Members of the General Assembly shall be ineligible to serve on boards, commissions, and councils within the executive branch of state government who are responsible for administering programs established by the General Assembly. Such prohibition shall not extend to boards, commissions, and councils engaged solely in policy studies or commemorative activities. If any law directs the appointment of any member of the General Assembly to a board, commission, or council in the executive branch of state government that is responsible for administering programs established by the General Assembly, such portion of such law shall be void, and the Governor shall appoint another person from the Commonwealth at large to fill such a position.

The provisions of this section shall not apply to members of the Board for Branch Pilots, who shall be appointed as provided for in § 54.1-901; to members of the Board of Trustees of the Southwest Virginia Higher Education Center, who shall be appointed as provided for in § 23-231.3; to members of the Board of Trustees of the Southern Virginia Higher Education Center, who shall be appointed as provided for in § 23-231.25; to members of the Board of Directors of the New College Institute who shall be appointed as provided for in § 23-231.31; to members of the Virginia Interagency Coordinating Council who shall be appointed as provided for in § 2.2-5204; to members of the Board of Veterans Services, who shall be appointed as provided for in § 2.2-2452; to members appointed to the Board of Trustees of the Roanoke Higher Education Authority pursuant to § 23-231.15; to members of the Commonwealth Competition Commission, who shall be appointed as provided for in § 2.2-2621; to members of the Virginia Geographic Information Network Advisory Board, who shall be appointed as provided for in § 2.2-2423; to members of the Advisory Commission on the Virginia Schools for the Deaf and the Blind, who shall be appointed as provided for in § 22.1-346.1; to members of the Substance Abuse Services Council, who shall be appointed as provided for in § 2.2-2696; to members of the Criminal Justice Services Board, who shall be appointed as provided in § 9.1-108; to members of the State Executive Council for Comprehensive Services for At-Risk Youth and Families, who shall be appointed as provided in § 2.2-2648; to members of the Virginia Workforce Council, who shall be appointed as provided for in § 2.2-2669; to members of the Commission on Civics Education, who shall be appointed as provided for in § 22.1-212.18; to members of the Volunteer Firefighters' and Rescue Squad Workers' Service Award Fund Board, who shall be appointed as provided for in § 51.1-1201; to members of the Secure Commonwealth Panel, who shall be appointed as provided for in § 2.2-306; to members of the Forensic Science Board, who shall be appointed as provided for in § 9.1-1109; or to members of the Virginia Commission on Immigration, who shall be appointed as provided in § 2.2-2530; or to members of the VirginiaShare Health Insurance Program Board, who shall be appointed as provided for in § 32.1-370.

§ 2.2-2101. (Contingent effective date, see Editor's note) Prohibition against service by legislators on boards, commissions, and councils within the executive branch; exceptions.

Members of the General Assembly shall be ineligible to serve on boards, commissions, and councils within the executive branch of state government who are responsible for administering programs

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 64 person from the Commonwealth at large to fill such a position.

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 71 Council who shall be appointed as provided for in § 2.2-5204; to members of the Board of Veterans  
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 82 appointed as provided for in § 2.2-2669; to members of the Commission on Civics Education, who shall  
 83 be appointed as provided for in § 22.1-212.18; to members of the Volunteer Firefighters' and Rescue  
 84 Squad Workers' Service Award Fund Board, who shall be appointed as provided for in § 51.1-1201; to  
 85 members of the Secure Commonwealth Panel, who shall be appointed as provided for in § 2.2-306; ~~or~~ to  
 86 members of the Forensic Science Board, who shall be appointed as provided for in § 9.1-1109; *or to*  
 87 *members of the VirginiaShare Health Insurance Program Board, who shall be appointed as provided for*  
 88 *in § 32.1-370.*

#### 89 CHAPTER 16.

#### 90 VIRGINIASHARE HEALTH INSURANCE PROGRAM.

91 § 32.1-368. *VirginiaShare Health Insurance Program established.*

92 *There is hereby established the VirginiaShare Health Insurance Program (the Program). The purpose*  
 93 *of the Program shall be to provide health insurance premium assistance to allow eligible low-income*  
 94 *working individuals to purchase health insurance coverage through a Certified VirginiaShare Health*  
 95 *Insurance Policy.*

96 § 32.1-369. *Definitions.*

97 *As used in this chapter, unless the context requires otherwise or it is otherwise provided:*

98 *"Board" means the VirginiaShare Health Insurance Program Board.*

99 *"Certified VirginiaShare Health Insurance Policy" means a VirginiaShare Health Insurance Policy,*  
 100 *developed pursuant to Article 5.1 (§ 38.2-3438 et seq.) of Chapter 34 of Title 38.2, that has been*  
 101 *certified by the Board, for which individuals employed by qualified small employers may qualify for*  
 102 *premium assistance as authorized by this chapter.*

103 *"Department" means the Department of Medical Assistance Services.*

104 *"Federal poverty level" means the poverty level promulgated and periodically updated by the U.S.*  
 105 *Department of Health and Human Services in the Federal Register, under the authority of 42 U.S.C.*  
 106 *9902(2).*

107 *"Qualified small employer" means an employer located in Virginia that employed at least two but not*  
 108 *more than 50 employees on business days during the preceding calendar year and that has not offered*  
 109 *health insurance to its employees during the six months prior to applying for participation in the*  
 110 *VirginiaShare Health Insurance Program.*

111 § 32.1-370. *VirginiaShare Health Insurance Program Board.*

112 *A. There is hereby established the State VirginiaShare Health Insurance Board as a policy board*  
 113 *within the meaning of § 2.2-2100, in the executive branch of state government. The Board shall consist*  
 114 *of 13 residents of the Commonwealth, as follows: the Secretary of Health and Human Resources shall*  
 115 *be a member and shall serve as Chairman of the Board; five members appointed by the Governor,*  
 116 *including two members who represent health insurance companies, one member who represents*  
 117 *insurance brokers and agents, one member who represents small businesses, and one member who*  
 118 *represents health care providers; three members appointed by the Speaker of the House of Delegates*  
 119 *including one member of the House of Delegates, one member who represents the Virginia Chamber of*  
 120 *Commerce, and one member who represents health insurance consumers; two members appointed by the*

Senate Committee on Rules including one member of the Senate of Virginia and one member representing small business; the Commissioner of the State Corporation Commission's Bureau of Insurance or his designee and the Director of the Department of Medical Assistance Services shall serve as ex officio members without voting privileges.

B. After the initial staggering of terms, all appointments shall be for four years, except that appointments to fill vacancies shall be made for the unexpired terms.

C. The Board shall meet as necessary and at such time and location as agreed by the Board. A majority of the members shall constitute a quorum. The Board shall conduct its business in accordance with the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

D. The Board shall promulgate regulations to implement the provisions of this chapter in accordance with the Administrative Process Act (§ 2.2-4000 et seq.).

E. The Board shall issue an annual report on the status of the Program to the Governor and the chairmen of the House Appropriations and Senate Finance Committees no later than May 1 of each year. The report shall include information on the operation and administration of the Program including, but not limited to, (i) the number of participating qualified small employers, (ii) the number of individuals covered under the Program, (iii) the number of covered individuals exceeding the claims threshold, (iv) the number of small employers denied participation in the Program, (v) the status of the VirginiaShare Health Insurance Program Fund, as established in § 32.1-376, and (vi) any issues related to the Program that may need to be addressed.

§ 32.1-371. Powers and duties of the Board.

A. The Board shall promulgate regulations to implement the provisions of this chapter. Such regulations shall include a procedure for paying the premium contributions from qualified small employers and eligible individuals, along with the premium assistance authorized by this chapter to the insurer, in a manner that gives constant coverage to the eligible individuals.

B. The Board shall establish a process for the certification of VirginiaShare Health Insurance Policies developed pursuant to Article 5.1 (§ 38.2-3438 et seq.) of Chapter 34 of Title 38.2. In certifying such plans, the Board may:

1. Specify minimum requirements with respect to the health benefits to be covered by the plan, which shall prioritize preventive health services. The Board shall consider requiring the plan to cover generic prescription drugs and physicians visits with limited cost-sharing. The Board may permit limitations on the amount of such services covered by the plan and may permit increased cost-sharing at higher utilization levels;

2. Establish incentives for the development of benefit packages emphasizing preventive and primary care;

3. Specify requirements with respect to plan coverage of dependents of eligible individuals. The Board may establish separate premium contribution levels for the state, employers, and employees with respect to dependent coverage;

4. Specify requirements with respect to the coverage of maternity services;

5. Specify requirements with respect to the coverage of exclusions of preexisting conditions, provided that no preexisting condition provision subjects an eligible individual to a preexisting condition exclusion period greater than 12 months;

6. Specify requirements with respect to eligible individual cost-sharing;

7. Specify a maximum policy year claims threshold;

8. Specify requirements with respect to the application and enrollment process;

9. Specify requirements with respect to continuing coverage for eligible individuals who leave employment of an qualified small employer;

10. Specify applicable marketing guidelines, including the use of an existing commercial brokerage or agent network;

11. Specify applicable reporting requirements of insurers;

12. Allow for the establishment of premium discounts for healthy behaviors, including abstaining from tobacco use and maintaining a healthy body mass index; and

13. Include any other requirements or incentives the Board deems appropriate.

C. The Board may enter into contracts with one or more insurers selected through a competitive bidding process to provide Certified VirginiaShare Health Insurance Policies to eligible individuals.

D. On an annual basis, the Board shall determine the Commonwealth's maximum premium assistance amount for eligible individuals, including for any dependent coverage.

§ 32.1-372. Department of Medical Assistance Services to administer.

A. The Department shall administer the Program in accordance with the regulations promulgated by the Board.

B. The finances, assets, liabilities, and administrative costs and all other financial transactions of the Program shall be maintained and accounted for separately from the Medicaid program administered

182 pursuant to § 32.1-325 and the Family Access to Medical Insurance Security Program (§ 32.1-351 et  
183 seq.) and all other programs administered by the Department.

184 § 32.1-373. VirginiaShare Health Insurance Program.

185 A. The VirginiaShare Health Insurance Program shall provide monthly health insurance premium  
186 assistance on behalf of low-income individuals who are employed by a qualified small employer. Such  
187 payments shall be made only on behalf of individuals determined eligible for the Program pursuant to  
188 § 32.1-374, and who are enrolled in or insured under a Certified VaShare Health Insurance Policy.

189 B. No insurer shall offer or market any insurance product as a Certified VaShare Health Insurance  
190 Policy without first receiving prior written approval by the Board. Insurers desiring to sell a Certified  
191 VaShare Health Insurance Policy shall submit information and documentation as required by the Board  
192 such that the Board can determine that the proposed policy meets the requirements for being a Certified  
193 VaShare Health Insurance Policy. Such information shall be submitted in the manner and format  
194 established by the Board.

195 C. The monthly premium assistance paid by the Program shall be equal to one-third of the total  
196 monthly premium for an eligible employee enrolled in or insured under a Certified VaShare Health  
197 Insurance Policy up to a maximum of \$75 per month. Of the remaining monthly premium amount, at  
198 least one-half shall be paid by the insured individual's qualified small employer, and the remaining  
199 amount shall be paid by the insured individual. Should the \$75 maximum payment be less than one-third  
200 of the total monthly premium, the insured individual and qualified small employer shall pay the  
201 remaining amount as they mutually agree.

202 D. Insurers who enroll eligible individuals into a Certified VaShare Health Insurance Policy shall  
203 submit documentation to the Department in the manner and format established by the Board in order to  
204 receive the VirginiaShare Health Insurance Program premium assistance as provided in this chapter.  
205 The Department shall ensure that all applicable requirements of this chapter and any applicable  
206 requirements contained in regulations promulgated by the Board are satisfied prior to paying the  
207 premium assistance.

208 E. Insurers participating in the Program shall be subject to audit by the Department to ensure  
209 proper administration, reporting, and accounting of Program premium assistance payments.

210 F. The Board shall ensure, to the greatest extent possible, that coverage under this program does not  
211 substitute for existing commercial health insurance coverage available in the Commonwealth.

212 § 32.1-374. Eligibility.

213 A. In order to be eligible for the Program an individual shall (i) be a resident of Virginia; (ii) have  
214 an income that is at or below 200 percent of the federal poverty level; (iii) have not been insured or  
215 had the offer of insurance within six months prior to enrollment in the Program; (iv) be ineligible for  
216 medical assistance benefits pursuant to Title XIX of the Social Security Act, as amended, or benefits  
217 pursuant to Title XXI of the Social Security Act, as amended; (v) be employed by a qualified small  
218 employer; and (vi) work at least 30 hours per week for the qualified small employer.

219 B. Individuals who meet all of the requirements of subsection A except for subdivision (ii) shall be  
220 eligible for coverage under a Certified VaShare Health Insurance Policy; however, the entire monthly  
221 premium for such individuals shall be paid by the individual and the individual's qualified small  
222 employer in such amounts as they mutually agree. No premium assistance shall be paid by the  
223 Commonwealth on behalf of such individuals.

224 § 32.1-375. No entitlement to coverage.

225 This chapter shall not be construed as creating any legally enforceable right or entitlement to  
226 benefits under the Program on the part of any person or any right or entitlement to participation. The  
227 Board and the Department shall approve and process monthly premium assistance payments only to the  
228 extent funds are made available or as otherwise directed by an appropriations act. The Program and  
229 any benefits provided hereunder shall not be public assistance pursuant to Chapter 5 (§ 63.2-500 et  
230 seq.) of Title 63.2.

231 § 32.1-376. VirginiaShare Health Insurance Program Fund established.

232 A. There is hereby created in the state treasury a special nonreverting fund to be known as the  
233 VirginiaShare Health Insurance Program Fund, hereafter referred to as "the Fund." The Fund shall be  
234 established on the books of the Comptroller. All funds as may be appropriated and any nongeneral  
235 funds that may be authorized by the federal government shall be paid into the state treasury and  
236 credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited  
237 to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall  
238 not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for  
239 the purposes of the Program as set out in this chapter, including costs to administer the Program.  
240 Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued  
241 by the Comptroller upon written request signed by Director of the Department.

242 B. The Auditor of Public Accounts or his legally authorized representative shall annually audit the  
243 accounts of the Fund in accordance with generally accepted auditing standards, and the cost of such

*audit services shall be borne by the Fund.*

*§ 32.1-377. Waiting list.*

*Should moneys in the Fund be insufficient to provide premium assistance for all eligible individuals enrolled in a Certified VaShare Health Insurance Policy, the Board shall establish and maintain a first-come, first-served waiting list. As funds become available, the Board shall approve and make such premium assistance based on the individual's place on the waiting list.*

*§ 38.2-3407.12. Patient optional point-of-service benefit.*

*A. As used in this section:*

*"Affiliate" shall have the meaning set forth in § 38.2-1322.*

*"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.*

*"Carrier" means:*

*1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;*

*2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services plans which are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;*

*3. Any health maintenance organization licensed under this title which provides or arranges for the provision of one or more health care plans which are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;*

*4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans which are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and*

*5. Any other person licensed under this title which provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels which are subject to regulation as the business of insurance under this title.*

*"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service which is not paid by the carrier and for which the enrollee is responsible.*

*"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the enrollee to the provider towards the allowable charge as a condition of the receipt of specific health care items and services.*

*"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the enrollee as a condition to or consequence of the receipt of covered items or services.*

*"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.*

*"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.*

*"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.*

*"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C.*

305 "Group specific administrative cost" means the direct administrative cost incurred by a carrier related  
306 to the offer of the point-of-service benefit to a particular group contract holder.

307 "Health care plan" shall have the meaning set forth in § 38.2-4300.

308 "Person" means any individual, corporation, trust, association, partnership, limited liability company,  
309 organization or other entity.

310 "Point-of-service benefit" means a health maintenance organization's delivery system or covered  
311 benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with  
312 the health maintenance organization, which permit an enrollee (and eligible dependents) to receive  
313 covered items and services outside of the provider panel, including optometrists and clinical  
314 psychologists, of the health maintenance organization under the terms and conditions of the group  
315 contract holder's group health benefit plan with the health maintenance organization or with another  
316 carrier arranged by or under contract with the health maintenance organization and which otherwise  
317 complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's  
318 indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health  
319 services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan  
320 under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee  
321 (and eligible dependents) to receive the full range of covered items and services outside of a provider  
322 panel, including optometrists and clinical psychologists, and which are otherwise in compliance with  
323 applicable law and this section shall constitute a point-of-service benefit.

324 "Preferred provider organization plan" means a health benefit program offered pursuant to a preferred  
325 provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider  
326 subscription contract under § 38.2-4209.

327 "Provider" means any physician, hospital or other person, including optometrists and clinical  
328 psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health  
329 care items or services.

330 "Provider panel" means the participating providers or referral providers who have a contract,  
331 agreement or arrangement with a health maintenance organization or other carrier, either directly or  
332 through an intermediary, and who have agreed to provide items or services to enrollees of the health  
333 maintenance organization or other carrier.

334 B. To the maximum extent permitted by applicable law, every health care plan offered or proposed  
335 to be offered in this Commonwealth by a health maintenance organization licensed under this title to a  
336 group contract holder shall provide or include, or the health maintenance organization shall arrange for  
337 or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered  
338 in conjunction with the health maintenance organization's health care plan as an additional benefit for  
339 the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group  
340 enrollment application, every health maintenance organization shall, at no additional cost to the group  
341 contract holder, make available or arrange with a carrier to make available to the prospective group  
342 contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each  
343 reenrollment, a notice in form and substance acceptable to the Commission which accurately and  
344 completely explains to the group contract holder and prospective enrollee the point-of-service benefit  
345 and permits each enrollee to make his or her election. The form of notice provided in connection with  
346 any reenrollment may be the same as the approved form of notice used in connection with initial  
347 enrollment and may be made available to the group contract holder and prospective enrollee by the  
348 carrier in any reasonable manner.

349 C. To the extent permitted under applicable law, a health maintenance organization providing or  
350 arranging, or contracting with another carrier to provide, the point-of-service benefit under this section  
351 and a carrier providing the point-of-service benefit required under this section under arrangement or  
352 contract with a health maintenance organization:

353 1. May not impose, or permit to be imposed, a minimum enrollee participation level on the  
354 point-of-service benefit alone;

355 2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or  
356 § 38.2-4221 for items or services provided under the point-of-service benefit required under this section  
357 solely on the basis of the license or certification of the provider to provide such items or services if the  
358 carrier otherwise covers the items or services provided and the provision of the items or services is  
359 within the provider's lawful scope of practice or authority; and

360 3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group  
361 prior to any enrollee electing to accept or reject the point-of-service benefit.

362 D. The premium imposed by a carrier with respect to enrollees who select the point-of-service  
363 benefit may be different from that imposed by the health maintenance organization with respect to  
364 enrollees who do not select the point-of-service benefit. Unless a group contract holder determines  
365 otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of  
366 any premium over the amount of the premium applicable to an enrollee who selects the coverage offered

by the health maintenance organization without the point-of-service benefit and for any identifiable group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization; provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) thirty percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service benefit any condition or penalty designed to discourage the enrollee's selection or use of the point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

428 H. Except as expressly otherwise permitted in this section or as otherwise required under applicable  
429 law, the scope of the health care items and services which are covered under the point-of-service benefit  
430 required under this section shall at least include the same health care items and services which would be  
431 covered if provided under the health maintenance organization's health care plan, including without  
432 limitation any items or services covered under a rider or endorsement to the applicable health care plan.  
433 Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing  
434 materials utilized with respect to such group health benefit plans that the scope of the benefits provided  
435 under the point-of-service option are at least as great as those provided through the HMO's health care  
436 plan for that group. Filings of point-of-service benefits submitted to the Commission shall be  
437 accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the  
438 point-of-service benefits includes at a minimum the same health care items and services as are provided  
439 under the HMO's group health care plan for that group.

440 I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging  
441 the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the  
442 health maintenance organization's group health benefit plan which does not contain the point-of-service  
443 benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is  
444 offered in a manner which separates or otherwise differentiates it from the group health benefit plan  
445 which does not contain the point-of-service benefit.

446 J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable  
447 law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit  
448 under this section with respect to any group health benefit plan offered to a group contract holder if the  
449 health maintenance organization determines in good faith that the group contract holder will be  
450 concurrently offering another group health benefit plan or a self-insured or self-funded health benefit  
451 plan which allows the enrollees to access care from their provider of choice whether or not the provider  
452 is a member of the health maintenance organization's panel.

453 K. This section shall apply only to group health benefit plans issued in the Commonwealth in the  
454 commercial group market by carriers regulated by this title and shall not apply to (i) health care plans,  
455 contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the  
456 Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42  
457 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5  
458 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28  
459 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or  
460 long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless  
461 offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare  
462 supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in  
463 section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is  
464 self-insured or self-funded; ~~or~~ (v) the essential and standard health benefit plans developed pursuant to  
465 § 38.2-3431 C; or (vi) *VirginiaShare Health Insurance Policies developed pursuant to Article 5.1*  
466 *(§ 38.2-3438 et seq.) of this chapter.*

467 L. This section shall apply to group health benefit plans issued or renewed by carriers in this  
468 Commonwealth on or after July 1, 1998.

469 M. Nothing in this section shall operate to limit any rights or obligations arising under §§ 38.2-3407,  
470 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312 or § 38.2-4312.1.

471 N. If any provision of this section or its application to any person or circumstance is held invalid for  
472 any reason in a court of competent jurisdiction, the invalidity shall not affect the other provisions or any  
473 other application of this section which shall be given effect without the invalid provision or application,  
474 and for this purpose the provisions of this section are declared severable.

475 *Article 5.1.*

476 *VirginiaShare Health Insurance Policies.*

477 *§ 38.2-3438. Definitions.*

478 *For the purposes of this article:*

479 *"Board" means the VirginiaShare Health Insurance Program Board established pursuant to*  
480 *§ 32.1-370.*

481 *"Dependent" means the spouse of an eligible employee, subject to the applicable terms of the policy*  
482 *covering the eligible employee.*

483 *"Eligible employee" means an employee who satisfies the requirements set forth in § 32.1-374.*

484 *"Health insurance policy" means any individual or group accident and health insurance policy or*  
485 *subscription contract providing hospital, medical and surgical or major medical coverage in the*  
486 *Commonwealth. "Health insurance policy" does not mean accident only, credit, or disability insurance;*  
487 *coverage of Medicare services or federal employee health plans, pursuant to contracts with the United*  
488 *States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only*  
489 *or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited*



benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;
2. Medical condition (including both physical and mental illnesses);
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability (including conditions arising out of acts of domestic violence); or
8. Disability.

"Insurer" means an insurance company or health services plan licensed in the Commonwealth to write accident and sickness insurance.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from an insurer, including fees and other contributions associated with a VirginiaShare health insurance policy.

"Qualified small employer" has the same meaning ascribed to that term in § 32.1-369.

"VirginiaShare health insurance policy" means a health insurance policy that is certified by the Board pursuant to § 32.1-373.

§ 38.2-3439. Regulations.

The Commission may adopt regulations to enable it to establish and administer such standards relating to the provisions of this article as may be necessary to (i) implement the requirements of this article and (ii) assure that the Commonwealth's regulation of insurers is not preempted pursuant to P. L. 104-191 (The Health Insurance Portability & Accountability Act of 1996).

B. The Commission may revise or amend such regulations and may increase the scope of the regulations to the extent necessary to maintain federal approval of the Commonwealth's program for regulation of insurers pursuant to the requirements established by the United States Department of Health and Human Services.

§ 38.2-3440. Issuance of policies.

Insurers offering a VirginiaShare health insurance policy shall issue coverage to every eligible employee who elects to be covered under such policy, if the employee and employer have agreed to make the required premium payments.

§ 38.2-3441. VirginiaShare health insurance policies.

Each VirginiaShare health insurance policy shall satisfy all requirements established by the Board pursuant to § 32.1-371, as well as the requirements of this article, including the following:

1. The policy may include cost containment and cost sharing features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians and other health care providers, subject to the limitations set forth in § 38.2-3407; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; co-payment, co-insurance, deductible or other cost sharing arrangement as those terms are defined in § 38.2-3407.12; or other managed care provisions.

2. No law requiring the coverage or offering of coverage of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16, 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, or § 38.2-4221 shall apply to the policy or riders thereof.

3. All policies shall use a policy form approved by the Commission providing coverage that complies with regulations promulgated by the Board pursuant to § 32.1-371. A health insurance issuer shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. The Commission at any time

551 may, after providing notice and an opportunity for a hearing to a health insurance issuer, disapprove  
552 the continued use by the health insurance issuer of a policy on the grounds that such policy does not  
553 meet the requirements of this article.

554 § 38.2-3442. Market conduct.

555 In order to ensure the broadest availability of VirginiaShare health insurance policies, the  
556 Commission shall set market conduct and other requirements for insurers and agents, including  
557 requirements relating to the following:

558 1. Documentation from each insurer that its VirginiaShare health insurance policies have been  
559 certified by the Board;

560 2. Publication by the Commission of a list of all insurers who offer VirginiaShare health insurance  
561 policies;

562 3. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of  
563 Insurance for access by small employers and their employees to information concerning this article; and

564 4. Periodic reports by insurers about VirginiaShare health insurance policies issued, provided that  
565 reporting requirements shall be limited to information concerning case characteristics and numbers of  
566 health insurance policies in various categories marketed or issued. Insurers shall maintain data relating  
567 to the VirginiaShare health insurance policies separate from data relating to additional benefits made  
568 available by rider for the purpose of complying with the reporting requirements of this section.

569 § 38.2-3443. Renewability.

570 If coverage pursuant to this article ceases to be written, administered or otherwise provided, such  
571 coverage shall continue to be governed by this article with respect to business conducted under this  
572 article that was transacted prior to the effective date of termination and that remains in force.

573 § 38.2-3444. Availability.

574 A. If VirginiaShare health insurance policies are offered under this article, they shall be offered and  
575 made available to all eligible employees of every qualified small employer, and their spouses, that apply  
576 for such coverage, and no coverage may be offered only to certain eligible employees or their spouses,  
577 except as provided in § 32.1-375. No employees or their spouses may be excluded or charged additional  
578 premiums because of health status; and

579 B. No coverage offered under this article shall exclude an eligible employee based solely on the  
580 nature of the employer's business.

581 C. Nothing in this article shall be construed to preclude an insurer from establishing employer  
582 contribution rules or group participation rules adopted by the Board in connection with VirginiaShare  
583 health insurance policies.

584 § 38.2-3445. Limitation on preexisting condition exclusion period.

585 A health insurer offering a health insurance policy may impose a preexisting limitation only if, and  
586 to the extent, permitted under regulations promulgated by the Commission.

587 § 38.2-3446. Disclosure of information.

588 A. Any insurer issuing VirginiaShare health insurance policies shall make a reasonable disclosure of  
589 the availability of information to a qualified small employer and its eligible employees, as part of its  
590 solicitation and sales materials, and upon request of such an employer, information concerning: (i) the  
591 provisions of such coverage concerning the health insurance issuer's right to change premium rates and  
592 the factors that may affect changes in premium rates; (ii) the provisions of such coverage relating to  
593 renewability of coverage; and (iii) the provisions of such coverage relating to any preexisting condition  
594 exclusion.

595 B. An insurer is not required under this article to disclose any information that is proprietary and  
596 trade secret information.

597 § 38.2-3447. Eligibility.

598 A. An insurer offering VirginiaShare health insurance policies may not establish rules for eligibility,  
599 including continued eligibility, of any individual under the terms of a policy based on any of the health  
600 status-related factors.

601 B. The provisions of this section shall not be construed:

602 1. To require the policy to provide particular benefits other than those provided under the terms of  
603 such plan or coverage; or

604 2. To prevent a health insurance issuer from establishing limitations or restrictions on the amount,  
605 level, extent or nature of the benefits or coverage for similarly situated insured individuals or coverage  
606 rules for eligibility to enroll under a policy which includes rules defining any applicable waiting periods  
607 for such enrollment.

608 C. A health insurance issuer offering VirginiaShare health insurance policies may not require an  
609 individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or  
610 contribution which is greater than the amount approved by the Board with respect to the policy.

611 2. That the Board shall promulgate regulations to implement the provisions of this act to be  
612 effective within 280 days of its enactment.

613 3. That the initial appointments to the Board shall be made by July 1, 2008, as follows: the  
614 Governor shall appoint two members for a term of one year each, two members for a term of two  
615 years each, and one member for a term of three years; the Speaker of the House shall appoint one  
616 member for a term of two years, one member for a term of three years, and one member for a  
617 term of four years; and the Senate Committee on Rules shall appoint one member for a term of  
618 three years and one member for a term of four years.  
619 4. That the provisions of this act shall expire on July 1, 2011.

**INTRODUCED**

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