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HOUSE BILL NO. 58

Offered January 13, 2016

Prefiled December 3, 2015

A BILL to amend and reenact §§ 38.2-3406.1, 38.2-3431, and 38.2-3551 of the Code of Virginia, relating to health benefits plans; large employers and small employers.

Patrons—Byron, Head, Yancey, Adams, Albo, Anderson, Bell, Richard P., Bell, Robert B., Campbell, Cox, Edmunds, Fowler, Garrett, Greason, Habeeb, Helsel, Hugo, Kilgore, Landes, Leftwich, Lingamfelter, Massie, Miller, O'Bannon, O'Quinn, Pogge, Poindexter, Robinson, Rush and Wright

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3406.1, 38.2-3431, and 38.2-3551 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3406.1. Application of requirements that policies offered by small employers include state-mandated health benefits.

A. As used in this section:

"Eligible individual" means an individual who is employed by a small employer and has satisfied applicable waiting period requirements.

"Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under a group policy of accident and sickness insurance, hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, which coverage is subject to this title or is provided under a plan regulated under the Employee Retirement Income Security Act of 1974.

"Health insurer" means any insurance company that issues accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, a corporation that provides accident and sickness subscription contracts, or any health maintenance organization that provides a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services, that is licensed to engage in such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b)(2)).

"Small employer" means, with respect to a calendar year and a plan year, an employer located in the Commonwealth that employed an average of at least one but not more than 50 eligible individuals on business days during the preceding calendar year and who employs at least one eligible individual on the date a policy under this section becomes effective. ~~Effective January 1, 2016, "small employer" means, with respect to a calendar year and a plan year, an employer located in the Commonwealth that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the date a policy under this section becomes effective.~~

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any coverage, or the 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. For purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

B. Notwithstanding any statute, rule, or regulation to the contrary, and for the purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a group accident and sickness subscription contract providing health insurance coverage for eligible individuals; and a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services that is offered, sold, or issued by a health insurer to a small employer:

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57 1. Shall not be required to include coverage, or the offer of coverage, for any state-mandated health
58 benefit, except for:

- 59 a. Coverage for mammograms pursuant to § 38.2-3418.1;
- 60 b. Coverage for pap smears pursuant to § 38.2-3418.1:2;
- 61 c. Coverage for PSA testing pursuant to § 38.2-3418.7; and
- 62 d. Coverage for colorectal cancer screening pursuant to § 38.2-3418.7:1.

63 2. May include any, or none, of the state-mandated health benefits not otherwise noted in subdivision
64 B 1 as the health insurer and the small employer shall agree.

65 Notwithstanding any provision of this section to the contrary, if any plan authorized by this section
66 includes and offers health care services covered by the plan that may be legally rendered by a health
67 care provider listed in § 38.2-3408, that plan shall allow for the reimbursement of such covered services
68 when rendered by such provider. Unless otherwise provided in this section, this provision shall not
69 require any benefit be provided as a covered service.

70 C. Any application and any enrollment form used in connection with coverage under this section
71 shall prominently disclose that the policy, contract, or evidence of coverage is not required to provide
72 state-mandated health benefits, shall prominently disclose any and all state-mandated health benefits that
73 the policy, subscription contract, or evidence of coverage does not provide, and shall clearly describe all
74 eligibility requirements.

75 D. A policy form, subscription contract, or evidence of coverage issued under this section to a small
76 employer shall prominently disclose any and all state-mandated health benefits that the policy,
77 subscription contract, or evidence of coverage does not provide. Such disclosure shall also be included
78 in certificate forms or other evidences of coverage furnished to each participant. Health insurers
79 proposing to issue forms providing coverage under this section shall clearly disclose the intended
80 purposes for such policies, contracts, or evidences of coverage when submitting the forms to the
81 Commission for approval in accordance with § 38.2-316.

82 E. The Commission shall adopt any regulations necessary to implement this section.

83 F. The provisions of this section shall not apply in any instance in which the provisions of this
84 section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

85 **§ 38.2-3431. Application of article; definitions.**

86 A. This article applies to group health plans and to health insurance issuers offering group health
87 insurance coverage, and individual policies offered to employees of small employers.

88 Each insurer proposing to issue individual or group accident and sickness insurance policies
89 providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each
90 corporation providing individual or group accident and sickness subscription contracts, and each health
91 maintenance organization or multiple employer welfare arrangement providing health care plans for
92 health care services that offers individual or group coverage to the small employer market in this
93 Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to
94 employees of a small employer shall be subject to the provisions of this article if any of the following
95 conditions are met:

96 1. Any portion of the premiums or benefits is paid by or on behalf of the employer;

97 2. The eligible employee or dependent is reimbursed, whether through wage adjustments or
98 otherwise, by or on behalf of the employer for any portion of the premium;

99 3. The employer has permitted payroll deduction for the covered individual and any portion of the
100 premium is paid by the employer, provided that the health insurance issuer providing individual
101 coverage under such circumstances shall be registered as a health insurance issuer in the small group
102 market under this article, and shall have offered small employer group insurance to the employer in the
103 manner required under this article; or

104 4. The health benefit plan is treated by the employer or any of the covered individuals as part of a
105 plan or program for the purpose of § 106, 125, or 162 of the United States Internal Revenue Code.

106 B. For the purposes of this article:

107 "Actuarial certification" means a written statement by a member of the American Academy of
108 Actuaries or other individual acceptable to the Commission that a health insurance issuer is in
109 compliance with the provisions of this article based upon the person's examination, including a review of
110 the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer
111 in establishing premium rates for applicable insurance coverage.

112 "Affiliation period" means a period which, under the terms of the health insurance coverage offered
113 by a health maintenance organization, must expire before the health insurance coverage becomes
114 effective. The health maintenance organization is not required to provide health care services or benefits
115 during such period and no premium shall be charged to the participant or beneficiary for any coverage
116 during the period.

117 1. Such period shall begin on the enrollment date.

118 2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in this Commonwealth, an association which:

1. Has been actively in existence for at least five years;
2. Has been formed and maintained in good faith for purposes other than obtaining insurance;
3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);
4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);
5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and
6. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage if any under such COBRA continuation provision, and the waiting period if any and affiliation period if applicable imposed with respect to the individual for any coverage under such plan.

"Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (33)).

"COBRA continuation provision" means any of the following:

1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;
2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or
3. Title XXII of P.L. 104-191.

"Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

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 section 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. Individual health insurance coverage.

Such term does not include coverage consisting solely of coverage of excepted benefits.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. At the employer's sole discretion, the eligibility criterion may be broadened to include part-time employees.

"Eligible individual" means such an individual in relation to the employer as shall be determined:

1. In accordance with the terms of such plan;
2. As provided by the health insurance issuer under rules of the health insurance issuer which are uniformly applicable to employers in the group market; and
3. In accordance with all applicable law of this Commonwealth governing such issuer and such market.

"Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

"Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or more employees.

"Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if

180 earlier, the first day of the waiting period for such enrollment.

181 "Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

182 1. Benefits not subject to requirements of this article:

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

184 b. Coverage issued as a supplement to liability insurance;

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

186 d. Workers' compensation or similar insurance;

187 e. Medical expense and loss of income benefits;

188 f. Credit-only insurance;

189 g. Coverage for on-site medical clinics; and

190 h. Other similar insurance coverage, specified in regulations, under which benefits for medical care

191 are secondary or incidental to other insurance benefits.

192 2. Benefits not subject to requirements of this article if offered separately:

193 a. Limited scope dental or vision benefits;

194 b. Benefits for long-term care, nursing home care, home health care, community-based care, or any

195 combination thereof; and

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

197 3. Benefits not subject to requirements of this article if offered as independent, noncoordinated

198 benefits:

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

200 b. Hospital indemnity or other fixed indemnity insurance.

201 4. Benefits not subject to requirements of this article if offered as separate insurance policy:

202 a. Medicare supplemental health insurance (as defined under section 1882 (g)(1) of the Social

203 Security Act (42 U.S.C. § 1395ss (g)(1));

204 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code

205 (10 U.S.C. § 1071 et seq.); and

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

207 "Federal governmental plan" means a governmental plan established or maintained for its employees

208 by the government of the United States or by an agency or instrumentality of such government.

209 "Governmental plan" has the meaning given such term under section 3(32) of the Employee

210 Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

211 "Group health insurance coverage" means in connection with a group health plan, health insurance

212 coverage offered in connection with such plan.

213 "Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the

214 Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan

215 provides medical care and including items and services paid for as medical care to employees or their

216 dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or

217 otherwise.

218 "Health benefit plan" means any accident and health insurance policy or certificate, health services

219 plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan

220 provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or

221 disability insurance; coverage of Medicare services or federal employee health plans, pursuant to

222 contracts with the United States government; Medicare supplement or long-term care insurance;

223 Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital

224 confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to

225 liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical

226 payment insurance; medical expense and loss of income benefits; or insurance under which benefits are

227 payable with or without regard to fault and that is statutorily required to be contained in any liability

228 insurance policy or equivalent self-insurance.

229 "Health insurance coverage" means benefits consisting of medical care (provided directly, through

230 insurance or reimbursement, or otherwise and including items and services paid for as medical care)

231 under any hospital or medical service policy or certificate, hospital or medical service plan contract, or

232 health maintenance organization contract offered by a health insurance issuer.

233 "Health insurance issuer" means an insurance company, or insurance organization (including a health

234 maintenance organization) which is licensed to engage in the business of insurance in this

235 Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within

236 the meaning of section 514 (b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C.

237 § 1144 (b)(2)). Such term does not include a group health plan.

238 "Health maintenance organization" means:

239 1. A federally qualified health maintenance organization;

240 2. An organization recognized under the laws of this Commonwealth as a health maintenance

241 organization; or

3. A similar organization regulated under the laws of this Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"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.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. Individual health insurance coverage does not include short-term limited duration coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means, in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. ~~Effective January 1, 2016, "large employer" means, in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.~~

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

1. The first period in which the individual is eligible to enroll under the plan; or
2. A special enrollment period as required pursuant to subsections J through M of § 38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
2. Transportation primarily for and essential to medical care referred to in subdivision 1; and
3. Insurance covering medical care referred to in subdivisions 1 and 2.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the health insurance issuer.

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (7)).

"Placed for adoption," or "placement" or "being placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"Plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16)(B)).

"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 a health insurance issuer, including fees and other contributions associated with the health benefit plan.

"Rating period" means the 12-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

303 "Service area" means a broad geographic area of the Commonwealth in which a health insurance
304 issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent
305 authorization to do business in Virginia.

306 "Small employer" means in connection with a group health plan or health insurance coverage with
307 respect to a calendar year and a plan year, an employer who employed an average of at least one but
308 not more than 50 employees on business days during the preceding calendar year and who employs at
309 least one employee on the first day of the plan year. ~~Effective January 1, 2016, "small employer" means~~
310 ~~in connection with a group health plan or health insurance coverage with respect to a calendar year and~~
311 ~~a plan year, an employer who employed an average of at least one but not more than 100 employees on~~
312 ~~business days during the preceding calendar year and who employs at least one employee on the first~~
313 ~~day of the plan year.~~

314 "Small group market" means the health insurance market under which individuals obtain health
315 insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents)
316 through a group health plan maintained by a small employer.

317 "State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands,
318 Guam, American Samoa, and the Northern Mariana Islands.

319 "Waiting period" means, with respect to a group health plan or health insurance coverage provided
320 by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan,
321 the period that must pass with respect to the individual before the individual is eligible to be covered for
322 benefits under the terms of the plan. If an employee or dependent enrolls during a special enrollment
323 period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before
324 such enrollment is not a waiting period.

325 C. The provisions of this section shall not apply in any instance in which the provisions of this
326 section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

327 **§ 38.2-3551. Definitions.**

328 A. As used in this article:

329 "Eligible dependent" means an individual who may be covered as a dependent under a group health
330 policy or policies and who is eligible, as determined by a small employer health group cooperative, for
331 coverage as a dependent of an eligible employee under a group health policy or policies issued to or
332 through such small employer health group cooperative.

333 "Eligible employee" means an employee who works for a small employer on a full-time basis, has a
334 normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not
335 a part-time, temporary, or substitute employee.

336 "Employer-member" means a small employer participating in a small employer health group
337 cooperative.

338 "Group health policy" or "policy" means a group insurance policy providing hospital, medical and
339 surgical or major medical coverage on an expense-incurred basis, a group accident and sickness
340 insurance policy or subscription contract, and a group health care plan for health care services or limited
341 health care services provided by a health maintenance organization. For the purposes of this article, a
342 group health policy or policy shall also mean a policy or plan provided by a dental or optometric
343 services plan, dental plan organization, and a health maintenance organization offering limited health
344 care services as defined in § 38.2-4300.

345 "Health insurance issuer" or "issuer" means a company authorized to issue coverage under Article 3
346 (§ 38.2-3521.1 et seq.) of Chapter 35, Chapter 42 (§ 38.2-4200 et seq.), Chapter 43 (§ 38.2-4300 et
347 seq.), Chapter 45 (§ 38.2-4500 et seq.), or Chapter 61 (§ 38.2-6100 et seq.) of this title.

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

- 351 1. Health status;
- 352 2. Medical condition, including both physical and mental illnesses;
- 353 3. Claims experience;
- 354 4. Receipt of health care;
- 355 5. Medical history;
- 356 6. Genetic information;
- 357 7. Evidence of insurability, including conditions arising out of acts of domestic violence; or
- 358 8. Disability.

359 "Service area" means the geographic area within which a health insurance issuer is authorized to sell
360 a group health policy or policies.

361 "Small employer" means, in connection with a group health policy with respect to a calendar year
362 and a plan year, an employer who employed an average of at least one but not more than 50 employees
363 on business days during the preceding calendar year and who employs at least one employee on the first
364 day of the plan year. ~~Effective January 1, 2016, "small employer" means, in connection with a group~~

365 health policy with respect to a calendar year and a plan year; an employer who employed an average of
366 at least one but not more than 100 employees on business days during the preceding calendar year and
367 who employs at least one employee on the first day of the plan year.

368 "Small employer health group cooperative" or "cooperative" means an entity authorized by its
369 employer-members to negotiate with health insurance issuers on their behalf as to the terms, including
370 premium rates, under which a group health policy or policies may be issued, providing coverage for the
371 eligible employees of such employer-members and their eligible dependents.

372 B. The provisions of this section shall not apply in any instance in which the provisions of this
373 section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

374 **2. That an emergency exists and this act is in force from its passage.**