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## SENATE BILL NO. 235

AMENDMENT IN THE NATURE OF A SUBSTITUTE  
(Proposed by the Senate Committee on Commerce and Labor  
on January 20, 2020)

(Patron Prior to Substitute—Senator Barker)  
Senate Amendments in [ ] - January 28, 2020

A *BILL to amend and reenact §§ 38.2-3431, 38.2-3437, and 38.2-3521.1 of the Code of Virginia, relating to health insurance; association health plans.*

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

**1. That §§ 38.2-3431, 38.2-3437, and 38.2-3521.1 of the Code of Virginia are amended and reenacted as follows:**

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

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

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

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

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

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

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

B. For the purposes of this article:

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

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

1. Such period shall begin on the enrollment date.

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.

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

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

67 "COBRA continuation provision" means any of the following:

68 1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection  
69 (f)(1) of such section insofar as it relates to pediatric vaccines;

70 2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29  
71 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

72 3. Title XXII of P.L. 104-191.

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

75 1. A group health plan;

76 2. Health insurance coverage;

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

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

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

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

82 7. A state health benefits risk pool;

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

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

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

86 11. Individual health insurance coverage.

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

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

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

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

95 1. In accordance with the terms of such plan;

96 2. As provided by the health insurance issuer under rules of the health insurance issuer which are  
97 uniformly applicable to employers in the group market; and

98 3. In accordance with all applicable law of this Commonwealth governing such issuer and such  
99 market.

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

102 "Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income  
103 Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two  
104 or more employees. *"Employer" includes an association described in subdivision E 1 of § 38.2-3521.1.*

105 "Enrollment date" means, with respect to an eligible individual covered under a group health plan or  
106 health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if  
107 earlier, the first day of the waiting period for such enrollment.

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

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

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

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

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

113 d. Workers' compensation or similar insurance;

114 e. Medical expense and loss of income benefits;

115 f. Credit-only insurance;

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

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

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

120 a. Limited scope dental or vision benefits;

121 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. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:

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

b. Hospital indemnity or other fixed indemnity insurance.

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

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

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

"Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

"Group health insurance coverage" means in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means 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)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees *and members and employees of employer members of an association described in subdivision E 1 of § 38.2-3521.1* or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only 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 insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in this Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within the meaning of section 514 (b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b)(2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

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

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

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

188 "Large employer" means, in connection with a group health plan or health insurance coverage with  
189 respect to a calendar year and a plan year, an employer who employed an average of at least 51  
190 employees on business days during the preceding calendar year and who employs at least one employee  
191 on the first day of the plan year. *"Large employer" includes an association described in subdivision E 1*  
192 *of § 38.2-3521.1 that includes at least 51 combined members and employees of employer members of*  
193 *such association on the first day of the plan year.*

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

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

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

202 "Medical care" means amounts paid for:

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

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

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

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

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

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

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

225 "Premium" means all moneys paid by an employer and eligible employees as a condition of coverage  
226 from a health insurance issuer, including fees and other contributions associated with the health benefit  
227 plan.

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

230 "Self-employed individual" means an individual who derives a substantial portion of his income from  
231 a trade or business (i) operated by the individual as a sole proprietor, (ii) through which the individual  
232 has attempted to earn taxable income, and (iii) for which he has filed the appropriate Internal Revenue  
233 Service Form 1040, Schedule C or F, for the previous taxable year.

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

237 "Small employer" means in connection with a group health plan or health insurance coverage with  
238 respect to a calendar year and a plan year, an employer who employed an average of at least one but  
239 not more than 50 employees on business days during the preceding calendar year and who employs at  
240 least one employee on the first day of the plan year. In determining whether a corporation or limited  
241 liability company employed an average of at least one individual during the preceding calendar year and  
242 employed at least one employee on the first day of the plan year, an individual who performed any  
243 service for remuneration under a contract of hire, written or oral, express or implied, for a (i)  
244 corporation of which the individual is a shareholder or an immediate family member of a shareholder or

(ii) a limited liability company of which the individual is a member shall be deemed to be an employee of the corporation or the limited liability company, respectively. However, a health insurance issuer shall not be required to issue more than one group health plan for each employer identification number issued by the Internal Revenue Service for a business entity, without regard to the number of shareholders or members of such business entity. "Small employer" includes a self-employed individual. *"Small employer" includes an association described in subdivision E 1 of § 38.2-3521.1 that includes 50 or fewer combined members and employees of employer members of such association on the first day of the plan year.*

"Small 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 small employer.

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

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

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

**§ 38.2-3437. Rules used to determine group size.**

A. All employers treated as a single employer under subsection (b), (c), (m), or (o) of § 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

B. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large group employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

C. *For the purposes of an association as described in subdivision E 1 of § 38.2-3521.1, all of the members and employees of employer members of such association shall be aggregated and treated as employed by a single employer.*

D. Any reference in this section to an employer shall include a reference to any predecessor of such employer.

**§ 38.2-3521.1. Group accident and sickness insurance definitions.**

Except as provided in § 38.2-3522.1, no policy of group accident and sickness insurance shall be delivered in this Commonwealth unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

B. A policy which is:

1. Not subject to Chapter 37.1 (§ 38.2-3727 et seq.) of this title, and

2. Issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall

306 include:

307 (1) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is  
308 arranged through a credit transaction;

309 (2) The debtors of one or more subsidiary corporations; and

310 (3) The debtors of one or more affiliated corporations, proprietorships or partnerships if the business  
311 of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common  
312 control.

313 b. The premium for the policy shall be paid either from the creditor's funds, or from charges  
314 collected from the insured debtors, or from both. Except as provided in subdivision 3 of this subsection,  
315 a policy on which no part of the premium is to be derived from funds contributed by insured debtors  
316 specifically for their insurance must insure all eligible debtors.

317 3. An insurer may exclude any debtors as to whom evidence of individual insurability is not  
318 satisfactory to the insurer.

319 4. The total amount of insurance payable with respect to an indebtedness shall not exceed the greater  
320 of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any  
321 payments which are delinquent on the date the debtor becomes disabled as defined in the policy.

322 5. The insurance may be payable to the creditor or any successor to the right, title, and interest of  
323 the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor  
324 to the extent of each such payment and any excess of the insurance shall be payable to the insured or  
325 the estate of the insured.

326 6. Notwithstanding the preceding provisions of this section, insurance on agricultural credit  
327 transaction commitments may be written up to the amount of the loan commitment. Insurance on  
328 educational credit transaction commitments may be written up to the amount of the loan commitment  
329 less the amount of any repayments made on the loan.

330 C. A policy issued to a labor union, or similar employee organization, which labor union or  
331 organization shall be deemed to be the policyholder, to insure members of such union or organization  
332 for the benefit of persons other than the union or organization or any of its officials, representatives, or  
333 agents, subject to the following requirements:

334 1. The members eligible for insurance under the policy shall be all of the members of the union or  
335 organization, or all of any class or classes thereof.

336 2. The premium for the policy shall be paid either from funds of the union or organization, or from  
337 funds contributed by the insured members specifically for their insurance, or from both. Except as  
338 provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived  
339 from funds contributed by the insured members specifically for their insurance must insure all eligible  
340 members, except those who reject such coverage in writing.

341 3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual  
342 insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

343 D. A policy issued (i) to or for a multiple employer welfare arrangement, a rural electric cooperative,  
344 or a rural electric telephone cooperative as these terms are defined in 29 U.S.C. § 1002, or (ii) to a trust,  
345 or to the trustees of a fund, established or adopted by or for two or more employers, or by one or more  
346 labor unions of similar employee organizations, or by one or more employers and one or more labor  
347 unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to  
348 insure employees of the employers or members of the unions or organizations for the benefit of persons  
349 other than the employers or the unions or organizations, subject to the following requirements:

350 1. The persons eligible for insurance shall be all of the employees of the employers or all of the  
351 members of the unions or organizations, or all of any class or classes thereof. The policy may provide  
352 that the term "employee" shall include the employees of one or more subsidiary corporations, and the  
353 employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or  
354 partnerships if the business of the employer and of such affiliated corporations, proprietorships or  
355 partnerships is under common control. The policy may provide that the term "employees" shall include  
356 retired employees, former employees and directors of a corporate employer. The policy may provide that  
357 the term "employees" shall include the trustees or their employees, or both, if their duties are principally  
358 connected with such trusteeship.

359 2. The premium for the policy shall be paid from funds contributed by the employer or employers of  
360 the insured persons, or by the union or unions or similar employee organizations, or by both, or from  
361 funds contributed by the insured persons or from both the insured persons and the employers or unions  
362 or similar employee organizations. Except as provided in subdivision 3 of this subsection, a policy on  
363 which no part of the premium is to be derived from funds contributed by the insured persons  
364 specifically for their insurance must insure all eligible persons, except those who reject such coverage in  
365 writing.

366 3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual  
367 insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

E. 1. A policy issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations which association or trust shall be deemed the policyholder. The association or associations shall:

- a. Have at the outset a minimum of 100 persons;
- b. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;
- c. Have been in active existence for at least five years;
- d. Have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees;
- e. 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);
- f. 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);
- g. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and
- h. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

*A member of such an association may include (i) a self-employed individual as defined in § 38.2-3431 and (ii) an employer member (a) with at least one employee that is domiciled in the Commonwealth or (b) that has a principal place of business that does not exceed the boundaries of a metropolitan area that is at least partially in the Commonwealth.*

2. The policy shall be subject to the following requirements:

- a. The policy may insure members of such association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer. *For this purpose, a member of such association may include (i) a self-employed individual as defined in § 38.2-3431 and (ii) an employer member with at least one employee that is domiciled in the Commonwealth.*
- b. The premium for the policy shall be paid from funds contributed by the association or associations, *or by members or by employer members, or by both all of them,* or from funds contributed by the covered persons or from both the covered persons and the association, associations, *members or employer members.*

3. Except as provided in subdivision 4 ~~of this subsection~~, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

4. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

5. *A policy issued to an association composed of (i) self-employed individuals as defined in § 38.2-3431 or (ii) employer members with at least one employee that is domiciled in the Commonwealth that do not share the same industry, trade, or profession or (iii) such individuals and employer members as described in both clauses (i) and (ii) shall (a) be considered a large group market plan subject to all coverage mandates applicable to a large group market plan offered in the Commonwealth and the large group market insurance regulations under the federal Public Health Service Act, P.L. 78-410, as amended; (b) be subject to the group health plan coverage requirements under the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended; (c) be prohibited from denying coverage under the policy based on a pre-existing condition as set forth in § 38.2-3444; (d) be guaranteed issue and guaranteed renewable; (e) provide essential health benefits and cost-sharing requirements as set forth in § 38.2-3451; and (f) offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan. [ This subdivision 5 shall not apply to an association composed of employer members in the same industry, trade, or profession. ]*

6. *The insurer issuing a policy to an association composed of (i) self-employed individuals as defined in § 38.2-3431 or (ii) employer members with at least one employee that is domiciled in the Commonwealth that do not share the same industry, trade, or profession or (iii) such individuals and employer members as described in both clauses (i) and (ii) shall (a) treat all of the members and employees of employer members who are enrolled in coverage under the policy as a single risk pool; (b) set premiums based on all of the collective group experience of the members and employees of employer members who are enrolled in coverage under the policy; (c) vary premiums by age, except that the rate shall not vary by more than five to one for adults; (d) not vary premiums based on gender; (e) be prohibited from varying premiums based on the health status of an individual employee of an*

429 *employer member or a self-employed individual member; and (f) not establish discriminatory rules based*  
430 *on the health status of an employer member, an individual employee of an employer member, or a*  
431 *self-employed individual for eligibility or contribution. [ This subdivision 6 shall not apply to an*  
432 *association composed of employer members in the same industry, trade, or profession. ]*

433 F. A policy issued to a credit union or to a trustee or trustees or agent designated by two or more  
434 credit unions, which credit union, trustee, trustees, or agent shall be deemed the policyholder, to insure  
435 members of such credit union or credit unions for the benefit of persons other than the credit union or  
436 credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

437 1. The members eligible for insurance shall be all of the members of the credit union or credit  
438 unions, or all of any class or classes thereof.

439 2. The premium for the policy shall be paid by the policyholder from the credit union's funds and,  
440 except as provided in subdivision 3 of this subsection, must insure all eligible members.

441 3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual  
442 insurability is not satisfactory to the insurer.

443 G. A policy issued to a health maintenance organization as provided in subsection B of § 38.2-4314.

444 H. A policy of blanket insurance issued in accordance with § 38.2-3521.2.

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

447 **2. That the Commissioner of Insurance shall, within 90 days of the enactment of this act, apply to**  
448 **the U.S. Secretary of Health and Human Services for a state innovation waiver under the federal**  
449 **Patient Protection and Affordable Care Act, P.L. 111-148, to implement the provisions of this act.**  
450 **Such waiver shall include (i) provisions authorizing (a) a self-employed individual and (b) an**  
451 **employer (1) with at least one employee that is domiciled in the Commonwealth or (2) that has a**  
452 **principal place of business that does not exceed the boundaries of a metropolitan area that is**  
453 **partially in the Commonwealth to participate in a group health plan issued to an association that**  
454 **is subject to the large group market insurance requirements and (ii) any other provisions the**  
455 **Commissioner of Insurance deems necessary to implement the provisions of this act.**

456 **3. That the provisions of the first enactment of this act shall become effective 30 days following**  
457 **the date the Commissioner of Insurance notifies the Governor and the Chairs of the House**  
458 **Committee on Labor and Commerce and the Senate Committee on Commerce and Labor of**  
459 **federal approval of the state innovation request required to be submitted by the Commissioner of**  
460 **Insurance pursuant to the second enactment of this act.**