VIRGINIA ACTS OF ASSEMBLY -- 1994 SESSION

CHAPTER 303

An Act to amend and reenact §§ 38.2-3431 through 38.2-3433 and 38.2-3523 of the Code of Virginia, relating to accident and sickness insurance.

[H 1345]

Approved April 4, 1994

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3431 through 38.2-3433 and 38.2-3523 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3431. Small employer market.

A. 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 coverage to the small employer or primary small employer market 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 small employer;

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

3. The small employer has permitted payroll deduction for the covered individual or any portion of the premium is paid by the small employer; 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 small employer carrier is in compliance with the provisions of ~~§ 38.2-3432~~ *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 small employer carrier in establishing premium rates for applicable health benefit plans.

~~"Affiliated companies" means companies that are affiliated or that are eligible to file a consolidated tax return which shall be treated as one carrier; provided, however that any insurance company or health services plan that is an affiliate of a health maintenance organization located in Virginia or any health maintenance organization located in Virginia that is an affiliate of an insurance company, or a health services plan, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area of Virginia may be considered a separate carrier.~~

"Carrier" means any person that provides one or more health benefit plans or insurance in this Commonwealth, including an insurer, a health services plan, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, a third party administrator or any other person providing a plan of health insurance subject to the authority of the Commission.

"Community rate" means the average rate charged for the same or similar coverage to all *primary small employer* groups with the same area, age and gender characteristics. *This rate shall be based on the carrier's combined claims experience for all groups within its primary small employer market.*

"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 thirty or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee.

"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection D of this section.

"Established geographic service area" means a broad geographic area of the Commonwealth in which a carrier sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"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; 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; 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.

"Initial enrollment period" means a period of at least thirty days.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the health benefit plan.

~~"Essential and standard health benefit plan" means health benefit plans developed pursuant to subsection D of this section.~~

"Preexisting conditions provision" means a policy provision that limits, denies, or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received within twelve months of the effective date of coverage.

"Premium" means all moneys paid by a small employer and eligible employees as a condition of coverage from a carrier, including fees and other contributions associated with the health benefit plan.

"Primary small employer," a subset of "small employer," means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed no more than twenty-five eligible employees and not less than two unrelated eligible employees, *except as provided in subdivision A 2 of § 38.2-3523*, the majority of whom are enrolled within this Commonwealth. Primary small employer includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a primary small employer shall apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this subsection.

"Rating period" means the twelve-month ~~calendar~~ period for which premium rates are determined by a small employer carrier and are assumed to be in effect.

"Small employer" or "small employer market" means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed less than fifty ~~full-time~~ *eligible* employees and not less than two unrelated ~~full-time~~ *eligible* employees, the majority of whom are employed within this Commonwealth. A small employer market group includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a small employer shall continue to apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this section.

"Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers or one or more primary small employers.

C. A late enrollee may be excluded from coverage for *up to* eighteen months *or may have a preexisting condition limitation apply for up to twelve months; however, in no case shall a late enrollee be excluded from some or all coverage for more than eighteen months*. ~~However,~~ An eligible employee or dependent shall not be considered a late enrollee if all of the conditions set forth below in subdivisions 1 through 4 are met or one of the conditions set forth below in subdivision 5 or 6 is met:

1. The individual was covered under a public or private health benefit plan at the time the individual was eligible to enroll.

2. The individual certified at the time of initial enrollment that coverage under another health benefit plan was the reason for declining enrollment.

3. The individual has lost coverage under a public or private health benefit plan as a result of termination of employment or employment status eligibility, the termination of the other plan's entire group coverage, death of a spouse, or divorce.

4. The individual requests enrollment within thirty days after termination of coverage provided under a public or private health benefit plan.

5. The individual is employed by a small employer that offers multiple health benefit plans and the individual elects a different plan offered by that small employer during an open enrollment period.

6. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan, the minor is eligible for coverage and is a dependent, and the request for enrollment is made within thirty days after issuance of such court order.

However, such individual may be considered a late enrollee for benefit riders or enhanced coverage levels not covered under the enrollee's prior plan.

D. The Commission shall adopt regulations establishing the essential and standard plans. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. Every small employer carrier shall, as a condition of transacting business in Virginia with *primary* small employers, ~~actively~~ offer to primary small employers at least the essential and standard plans. *However, any regulation adopted by the Commission shall contain a provision requiring all small employer carriers to offer an option permitting*

a primary small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a primary small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title. All small employer carriers shall issue the plans to every primary small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and ~~to~~ *shall* satisfy the following provisions:

1. Such plan may include cost containment 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 and 38.2-4209 and Chapter 43 of this title*; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, *if a health maintenance organization is federally qualified,* and of nonfederally qualified health maintenance organizations, *if a health maintenance organization is not federally qualified*. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for small employer carriers.

2. No law requiring the coverage or offering of coverage of a ~~health care service or~~ benefit shall apply to the essential *or standard* health care plan or riders thereof.

3. Within 180 days after the Commission's approval of essential and standard health benefit plans, every small employer carrier shall, *as a condition of transacting business in Virginia with primary small employers,* offer and make available to *primary* small employers an essential and a standard health benefit plan.

4. Within 180 days after the Commission's approval of essential and standard health benefit plans, every primary small employer that elects to be covered under either an essential or standard health benefit plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier *to become effective upon renewal or termination of any group health benefit plan which the small employer may be party to*.

5. All essential and standard benefit plans issued to primary small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than *and in addition to* the essential and standard plans may be provided by rider, *separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium.* A small employer carrier 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. Each rider, *separate policy or plan* providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, *separate policy or plan*. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a small employer carrier, disapprove the continued use by the small employer carrier of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

6. No small employer carrier is required to offer coverage or accept applications pursuant to ~~subdivision D~~ *subdivisions 3 and* 4 of this ~~section~~ *subsection*:

a. From a primary small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group prior to its anniversary date; or

b. If the Commission determines that acceptance of an application or applications would result in the carrier being declared an impaired insurer.

A small employer carrier that does not offer coverage pursuant to subdivision 6 b of this subsection may not offer coverage to small employers until the Commission determines that the carrier is no longer impaired.

7. Every small employer carrier shall uniformly apply the provisions of subdivision D 6 of this section and shall fairly market the essential and standard health benefit plans to all primary small employers in their established geographic service area of the Commonwealth. A small employer carrier that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the carrier submits and the Commission approves a plan to fairly market to their established geographic service area.

8. No health maintenance organization is required to offer coverage or accept applications pursuant to

~~subdivision D~~ *subdivisions 3 and* 4 of this ~~section~~ *subsection* in the case of any of the following:

a. To ~~primary~~ small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;

b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas; ~~or~~

c. To primary small employers if the health maintenance organization is a federally qualified health maintenance organization and it demonstrates to the satisfaction of the Commission that the federally qualified health maintenance organization is prevented from doing so by federal requirement; however, any such exemption under this subdivision would be limited to the essential plan; or

~~c.~~ *d.* Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than fifty eligible employees until the later of 180 days after closure to new applications or the date on which the carrier notifies the Commission that it has regained capacity to deliver services to small employers.

In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 7 of this subsection apply.

9. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for carriers, agents and third-party administrators, including requirements relating to the following:

a. Registration by each carrier with the Commission of its intention to be a small employer carrier under this article;

b. Publication by the Commission of a list of all small employer carriers, including a potential requirement applicable to agents, third-party administrators, and carriers that no health benefit plan may be sold to a small employer by a carrier not so identified as a small employer carrier;

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

d. To the extent deemed to be necessary to ensure the fair distribution of primary small employers among carriers, periodic reports by carriers about plans issued to primary small employers; provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to primary small employers. Carriers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and

e. Methods concerning periodic demonstration by small employer carriers that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

§ 38.2-3432. Small employer market subject to certain provisions.

A. Every individual or group policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth or providing benefits to or on behalf of a small employer pursuant to this article is subject to the following provisions:

1. Except in the case of a late enrollee, any preexisting-conditions provision may not limit, deny or exclude coverage for a period beyond twelve months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage or as to a pregnancy existing on the effective date of coverage.

2. A condition which would otherwise be covered pursuant to subdivision A 1 may not be excluded from coverage.

3. In determining whether a preexisting-conditions provision applies to an insured, all coverage shall credit the time the person was covered under previous individual or group policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, whether or not the new coverage is provided by a different employer, exclusive of any applicable waiting period under such coverage.

B. Coverage shall be renewable with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, contract holder or enrollee;

2. For abuse or misuse of a provider network provision;

3. For fraud or misrepresentation of the policyholder, contract holder or enrollee, with respect to their coverage;

4. When the employer is no longer actively engaged in the business in which it was engaged on the

effective date of the coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission;

7. When primary small employer new business ceases to be written by an insurer in the small employer market, provided that the following conditions are satisfied:

a. Notice of the decision to cease writing new business in the primary small employer market is provided to the Commission and to either the policyholder, contract holder, enrollee or employer;

b. Writing new business in the primary small employer market in this Commonwealth shall be prohibited for a period of three years from the date of notice to the Commission pursuant to this subdivision. In the case of a health maintenance organization which ceases to do new business in the small employer market in one service area of the Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in that service area;

c. When a small employer carrier ceases to write new business and renew business in the primary small employer market, it may continue to participate in the market of small employers which are not primary small employers if it complies with the provisions of this article applicable to the small employer market. Nothing in this provision shall prohibit a small employer carrier from writing and renewing business in the primary small employer market if it has ceased writing and renewing business to small employers which are not primary small employers; and

d. Health benefit plans subject to this article shall not be canceled for 180 days after the date of the notice required under subdivision 7 a of this subsection and for that business of a small employer carrier which remains in force, any small employer carrier that ceases to write new business in the small employer market shall continue to be governed by this article with respect to business conducted under this article; or

8. Benefits and premiums which have been added by rider to the essential or standard benefit plans issued to primary small employers shall be renewable at the sole option of the small employer carrier.

C. If coverage is offered under this article, such coverage shall be offered and made available to all of the eligible employees of a small employer and their dependents. No coverage may be offered to only certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status*; provided that small employer groups having policies, contracts or plans in effect prior to July 1, 1994, which charge different premiums to their employees or dependents because of health status, may, upon written request to the small employer carrier at the time of any renewal of such policy, contract or plan, continue to have different premiums charged to their employees and dependents because of health status; however, this ability to charge different premiums because of health status shall expire on July 1, 1997.*

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

E. No coverage offered under this article shall exclude an employer based solely on the nature of the employer's business.

§ 38.2-3433. Small employer market premium and disclosure provisions.

A. New or renewal premium rates for essential or standard health benefit plans issued by a small employer carrier to a primary small employer not currently enrolled with that same employer carrier shall be based on a community rate subject to the following conditions:

1. A small employer carrier may use the following risk classification factors in rating small groups: demographic rating, including age and gender; and geographic area rating. A small employer carrier may not use claim experience, health status, duration or other risk classification factors in rating such groups, except as provided in subdivision 2 of this subsection.

2. The premium rates charged by a small employer carrier may deviate ~~above or below~~ *from* the community rate filed by the small employer carrier by not more than twenty percent *above or twenty percent below such rate* for claim experience, health status and duration only during a rating period for such groups within a similar demographic risk classification for the same or similar coverage ~~or the rates that could be charged to such groups under the rating system~~. *Rates for a health benefit plan may vary based on the number of the eligible employee's enrolled dependents*.

3. Small employer carriers shall apply rating factors ~~including case characteristics~~ consistently with respect to all primary small employers in a similar demographic risk classification. Adjustments in rates for claims experience, health status and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the primary small employer.

~~B. A small employer carrier shall not involuntarily transfer a primary small employer into or out of a class of business. A small employer carrier shall not offer to transfer a primary small employer into or out of a class of business unless such offer is made to transfer all primary small employers in the class~~

~~of business without regard to case characteristics, claims experience, health status, or duration of coverage since issue.~~

~~C.~~ *B.* In connection with the offering for sale of any health benefit plan to a primary small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

1. The extent to which premium rates for a specific primary small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of such primary small employer;

2. Provisions relating to renewability of policies and contracts; and

3. Provisions affecting any preexisting conditions provision.

~~D.~~ *C.* Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices pertaining to its primary small employer business, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

~~E.~~ *D.* Each small employer carrier shall file with the Commission annually on or before March 15 *the community rates and* an actuarial certification certifying that ~~it is~~ *the carrier and its rates are* in compliance with this article. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

~~F.~~ *E.* A small employer carrier shall make the information and documentation described in subsection ~~D~~ *C* of this section available for review by the Commission upon request.

§ 38.2-3523. Group requirements.

A. A group accident and sickness insurance policy shall comply with the following requirements:

1. The members eligible for insurance under the policy shall be all the members of the group, or all of any class or classes of the group. However, an insurer may exclude or limit coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

2. A group accident and sickness insurance policy shall cover at least two persons, other than spouses or minor children, *unless determined to be an eligible employee as defined in § 38.2-3431,* at the issue date and at each policy anniversary date.

B. In addition to the requirements of subsection A of this section, group credit accident and sickness insurance as defined in § 38.2-3521 shall be subject to the following requirements:

1. 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 of debtors. The policy may provide that the term "debtors" shall include (i) borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction; (ii) the debtors of one or more subsidiary corporations; and (iii) the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control.

2. The premium for the policy shall be paid by the policyholder either from the creditor's funds or from charges collected from the insured debtors, 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 the collection of such identifiable charges must insure all eligible debtors.

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

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

5. The insurance shall be payable to the creditor, or any successor of the right, title or interest of the creditor. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

6. Notwithstanding the provisions of subdivisions 1 through 5 of this subsection, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.