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**HOUSE BILL NO. 2120**

Offered January 10, 2007

Prefiled January 8, 2007

A *BILL to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 63, consisting of sections numbered 38.2-6300 through 38.2-6313, relating to the Small Employer Health Insurance Exchange Act.*

Patron—Marshall, R.G.

Referred to Committee on Commerce and Labor

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

**1. That the Code of Virginia is amended by adding in Title 38.2 a chapter numbered 63, consisting of sections numbered 38.2-6300 through 38.2-6313, as follows:**

**CHAPTER 63.****SMALL EMPLOYER HEALTH INSURANCE EXCHANGE ACT.**

§ 38.2-6300.

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

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

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

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

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

1. A group health plan;
2. Health insurance coverage;
3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);
4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under 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. Any other qualifying coverage required by HIPAA as it may be amended or regulations promulgated under HIPAA.

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

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

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

1. The individual is a resident of the Commonwealth, meaning that the individual is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in Virginia that remains the person's principal residence and from which the person is absent only for temporary or transitory purpose, who is employed at least 20 hours a week on a regular basis at a Virginia location by an employer, and the individual's employer does not offer a group health insurance plan, or the individual is not eligible to participate in any group health insurance plan offered by his employer.

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

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

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59 individual.

60 "Employer" means an individual, partnership, association, corporation, legal representative, receiver,  
61 trustee, or trustee in bankruptcy doing business in or operating within the Commonwealth that employs  
62 no more than 100 employees.

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

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

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

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

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

68 d. Workers' compensation or similar insurance;

69 e. Medical expense and loss of income benefits;

70 f. Credit-only insurance;

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

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

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

76 a. Limited scope dental or vision benefits;

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

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

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

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

83 b. Hospital indemnity or other fixed indemnity insurance; and

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

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

88 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code  
89 (10 U.S.C. § 1071 et seq.); and

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

91 "Exchange" means the Small Employer Health Insurance Exchange established by this chapter.

92 "Federal health coverage tax credit eligible individual" means any individual who is eligible for  
93 benefits under section 201 of the Trade Act of 2002, approved August 6, 2002 (116 Stat. 933; 26 USC  
94 § 35(c) (2003)), as amended.

95 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, approved August  
96 21, 1996 (Pub. L. 104-191; 110 Stat. 1136).

97 "Participating employer plan" means a group health plan, as defined in federal law (§ 706 of ERISA  
98 (29 USC § 1186)), that is sponsored by an employer and for which the plan sponsor has entered into an  
99 agreement with the Exchange, in accordance with the provisions of this chapter, for the Exchange to  
100 offer and administer health insurance benefits for enrollees in the plan.

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

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

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

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

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

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

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

§ 38.2-6301. *Small Employer Health Insurance Exchange; creation; purpose.*

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

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

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

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

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

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

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

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

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

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

§ 38.2-6303. *Responsibilities of Exchange.*

The Exchange shall:

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

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

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

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

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

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

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

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

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

b. Enable participating individuals to pay, in whole or part, for coverage through the Exchange by

182 electing to assign to the Exchange any federal Earned Income Tax Credit payments due the  
183 participating individual; and  
184 c. Receive and process any federal or state tax credits or other premium support payments for health  
185 insurance, as may be established by law.

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

188 6. Establish procedures to account for all funds received and disbursed by the Exchange, including:  
189 a. Maintaining a separate, segregated Management Account for the receipt and disbursement of  
190 moneys allocated to fund the administration of the Exchange; and  
191 b. Maintaining a separate, segregated Operations Account for:  
192 (1) The receipt of all premium payments or contributions made by or on behalf of participating  
193 individuals; and  
194 (2) The distribution of premium payments to participating plans and of commissions or payments to  
195 licensed insurance producers and such other organizations as are permitted under § 38.2-6311 to  
196 receive payments for their services in enrolling eligible individuals or groups in the Exchange.

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

199 § 38.2-6304. Powers.  
200 The Exchange shall have the power to:  
201 1. Contract with vendors to perform one or more of the functions specified in § 38.2-6303.  
202 2. Contract with private or public social service agencies to administer applications, eligibility  
203 verification, enrollment, and premium payments for specified groups or populations of eligible  
204 individuals or participating individuals.  
205 3. Contract with employers to act as the plan administrator for participating employer plans, subject  
206 to the provisions of § 38.2-6310, and to undertake the obligations required by federal law of a plan  
207 administrator.  
208 4. Set and collect fees from participating individuals, participating employer plans, and participating  
209 insurance plans sufficient to fund the cost of administering the Exchange.

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

213 6. Establish and administer rules and procedures governing the operations of the Exchange.  
214 7. Establish one or more service centers within Virginia to facilitate enrollment.  
215 8. Sue and be sued or otherwise take any necessary or proper legal action.  
216 9. Establish bank accounts and borrow money.

217 § 38.2-6305. Enrollment and coverage election.  
218 A. Any eligible individual may apply to participate in the Exchange. An employer that has eligible  
219 individuals as employees may apply on behalf of those eligible persons. Upon determination by the  
220 Exchange that an individual is eligible in accordance with the provisions of this Act to participate in the  
221 Exchange, he may enroll or, when applicable, be enrolled by his parent or legal guardian, in a  
222 participating insurance plan offered through the Exchange during the next open season period or, when  
223 applicable, at such other times as are specified in subsection D.

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

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

229 D. Subject to the provisions of § 38.2-6307, an eligible individual may enroll in a health benefit plan  
230 offered through the Exchange, without a waiting period, and not be declined coverage, at a time other  
231 than the annual open season for any of the following reasons, provided the individual does so within 63  
232 days of the triggering event:  
233 1. The individual loses coverage in an existing health insurance plan due to the death of a spouse,  
234 parent, or legal guardian;  
235 2. The individual or a covered dependent loses coverage in an existing health insurance plan due to  
236 a change in the individual's employment status;  
237 3. The individual or a covered dependent loses coverage in an existing health insurance plan  
238 because of a divorce, separation, or other change in familial status;  
239 4. The individual loses coverage in an existing health insurance plan because he achieves an age at  
240 which coverage lapses under that plan;  
241 5. The individual or a covered dependent becomes newly eligible by becoming a resident of the  
242 Commonwealth or because the individual's place of employment has been changed to Virginia;  
243 6. The individual becomes newly eligible by becoming the spouse or dependent, by reason of birth,

adoption, court order, or a change in custody arrangement, of an eligible individual;

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

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

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

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

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

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

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

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

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

1. Withdrawal by the Commissioner; or

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

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

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

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

1. Hospital benefits;

2. Surgical benefits;

3. In-hospital medical benefits;

4. Ambulatory patient benefits;

5. Prescription drug benefits; and

6. Mental health benefits.

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

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

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

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

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

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

§ 38.2-6307. Underwriting rules.

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

1. Except as otherwise specified in subdivisions 3 and 4, during any open season a participating

individual who elects to choose a different participating insurance plan or plan option for the next plan year shall not be subject to any preexisting condition provisions and shall be charged the standard rate of the new participating insurance plan or plan option for persons of the participating individual's age and geographic area. The same shall apply to any election by a participating individual of coverage for any dependent who is also a participating individual.

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

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

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

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

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

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

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

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

§ 38.2-6308. Continuation of coverage.

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

§ 38.2-6309. Dispute resolution.

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

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

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

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

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

§ 38.2-6310. Participating employer plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 38.2-6311. Insurance producers.

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

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

§ 38.2-6312. Statement of coverage form.

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

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

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

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

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

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

444       E. The Commissioner shall prepare and distribute such forms.

445       § 38.2-6313. Insurance market consolidation.

446       A carrier shall not issue or renew a group health benefit plan to an employer, other than through  
447 the Exchange established under § 38.2-6301, after the first day of the plan year following the first  
448 regular open season conducted by the Exchange in accordance with § 38.2-6305. This section shall not  
449 apply to any health benefit plan that consists solely of one or more excepted benefits.

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