VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 32.1-352, 38.2-508, 38.2-3432.3, as it is currently effective and as it shall become effective, 38.2-3444, 38.2-4229.1, and 58.1-2501 of the Code of Virginia and to repeal § 38.2-4216.1 of the Code of Virginia, as it is currently effective and as it may become effective, relating to individual accident and sickness contracts; open enrollment program.

[H 1784]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-352, 38.2-508, 38.2-3432.3, as it is currently effective and as it shall become effective, 38.2-3444, 38.2-4229.1, and 58.1-2501 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-352. Virginia Family Access to Medical Insurance Security Plan Trust Fund.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Family Access to Medical Insurance Security Plan Trust Fund, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. The Fund shall consist of the premium differential, any and all employer contributions which may be solicited or received by the Department of Medical Assistance Services, grants, donations, gifts, and bequests, or any and all moneys designated for the Fund, from any source, public or private. As used in this section, "premium differential" means an amount equal to the difference between (i) 0.75 percent of the direct gross subscriber fee income derived from eligible contracts and (ii) the amount of license tax revenue generated pursuant to *former* subdivision A 4 of § 58.1-2501 with respect to eligible contracts. As used in this section, "eligible contract" means any subscription contract for any kind of plan classified and defined in § 38.2-4201 or 38.2-4501 issued other than to (i) an individual or (ii) a primary small group employer if income from the contract is subject to license tax at the rate of 2.25 percent pursuant to *former* subsection D of § 38.2-4229.1. The Department of Taxation shall annually, on or before June 30, calculate the premium differential for the immediately preceding taxable year and notify the Comptroller of the Commonwealth to transfer such amount to the Virginia Family Access to Medical Insurance Security Plan Trust Fund as established on the books of the Comptroller.

B. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely to support the Virginia Family Access to Medical Insurance Security Plan in accordance with the requirements of Title XXI of the Social Security Act, as amended, the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP), as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33), and any conditions set forth in the appropriation act.

C. The Director of the Department of Medical Assistance Services shall report annually on December 1 to the Governor, the General Assembly, and the Joint Commission on Health Care on the status of the Fund, the number of children served by this program, the costs of such services, and any issues related to the Virginia Family Access to Medical Insurance Security Plan that may need to be addressed.

§ 38.2-508. Unfair discrimination.

No person shall:

1. Unfairly discriminate or permit any unfair discrimination between individuals of the same class and equal expectation of life (i) in the rates charged for any life insurance or annuity contract, or (ii) in the dividends or other benefits payable on the contract, or (iii) in any other of the terms and conditions of the contract;

2. Unfairly discriminate or permit any unfair discrimination between individuals of the same class and of essentially the same hazard (i) in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance, (ii) in the benefits payable under such policy or contract, (iii) in any of the terms or conditions of such policy or contract, or (iv) in any other manner;

3. Refuse to insure, refuse to continue to insure, or limit the amount, extent or kind of insurance coverage available to an individual, or charge an individual a different rate for the same coverage solely because of blindness, or partial blindness, or mental or physical impairments, unless the refusal, limitation or rate differential is based on sound actuarial principles. This paragraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract;

4. Unfairly discriminate or permit any unfair discrimination between individuals or risks of the same

class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage solely because of the geographic location of the individual or risk, unless:

a. The refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

b. The refusal, cancellation or limitation is required by law or regulatory mandate;

5. Make or permit any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained in a residential property risk, solely because of the age of the residential property, unless:

a. The refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

b. The refusal, cancellation or limitation is required by law or regulatory mandate;

6. Refuse to issue or renew any individual accident and sickness insurance policy or contract for coverage over and above any lifetime benefit of a group accident and sickness policy or contract solely because an individual is insured under a group accident and sickness insurance policy or contract~~;~~, provided that medical expenses covered by both individual and group coverage shall be paid first by the group policy or contract to the extent of the group coverage~~.~~ ~~This subsection shall not apply to individual policies or contracts issued or renewed pursuant to § 38.2-4216.1~~; or

7. Consider the status of a victim of domestic violence as a criterion in any decision with regard to insurance underwriting, pricing, renewal, scope of coverage, or payment of claims on any and all insurance defined in § 38.2-100 and further classified in Article 2 (§ 38.2-101 et seq.) of Chapter 1 of this title, other than (i) legal services plans as provided for in Chapter 44 (§ 38.2-4400 et seq.) of this title and (ii) the insurance classified in §§ 38.2-110 through 38.2-133. The term "domestic violence" means the occurrence of one or more of the following acts by a current or former family member, household member as defined in § 16.1-228, person against whom the victim obtained a protective order or caretaker:

a. Attempting to cause or causing or threatening another person physical harm, severe emotional distress, psychological trauma, rape or sexual assault;

b. Engaging in a course of conduct or repeatedly committing acts toward another person, including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

c. Subjecting another person to false imprisonment; or

d. Attempting to cause or causing damage to property so as to intimidate or attempt to control the behavior of another person.

Nothing in this subsection shall prohibit an insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under an insurance policy even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know resulted from domestic violence, to the extent otherwise permitted under this section and other applicable law.

§ 38.2-3432.3. (Effective until July 1, 2014) Limitation on preexisting condition exclusion period.

A. Subject to subsection B, a health insurer offering health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting limitation only if:

1. For group health insurance coverage, such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

2. For individual health insurance coverage, such exclusion relates to a condition that, during a 12-month 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 12 months immediately preceding the effective date of coverage;

3. Such exclusion extends for a period of not more than 12 months (or 12 months in the case of a late enrollee) after the enrollment date; and

4. The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

B. Exceptions:

1. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or

placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

3. A health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, except in the case of individual health insurance coverage for a person who is not considered an eligible individual, as defined in § 38.2-3430.2, in which case the health insurance issuer may impose a preexisting condition exclusion for a pregnancy existing on the effective date of coverage;

4. Subdivisions 1 and 2 of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage; and

5. Subdivision A 4 shall not apply to health insurance coverage offered in the individual market on a "guarantee issue" basis without regard to health status including ~~open enrollment policies or contracts issued pursuant to § 38.2-4216.1 and~~ policies, contracts, certificates, or evidences of coverage issued through a bona fide association or to students through school sponsored programs at a college or university unless the person is an eligible individual as defined in § 38.2-3430.2.

C. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

D. For purposes of subdivision B 4 and subsection C, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period under subsection C.

E. Methods of crediting coverage:

1. Except as otherwise provided under subdivision 2 of this subsection, a health insurance issuer offering group health coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period;

2. A health insurance issuer offering group health insurance coverage may elect to count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits rather than as provided under subdivision 1 of this subsection. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category;

3. In the case of an election with respect to a group plan under subdivision 2 of this subsection (whether or not health insurance coverage is provided in connection with such plan), the plan shall: (i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election and (ii) include in such statements a description of the effect of this election; and

4. In the case of an election under subdivision 2 of this subsection with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall: (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election and (ii) include in such statements a description of the effect of such election.

F. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection G or in such other manner as may be specified in federal regulations.

G. A health insurance issuer offering group health insurance coverage shall provide for certification of the period of creditable coverage:

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

2. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under such provision; and

3. At the request, or on behalf of, an individual made not later than 24 months after the date of cessation of the coverage described in subdivision 1 or 2 of this subsection, whichever is later. The certification under subdivision 1 of this subsection may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

H. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

I. In the case of an election described in subdivision E 2 by a health insurance issuer, if the health insurance issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subsection F:

1. Upon request of such health insurance issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting group insurance issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

2. Such entity may charge the requesting health insurance issuer for the reasonable cost of disclosing such information.

J. A health insurance issuer offering group health insurance coverage shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time;

3. The employee's or dependent's coverage described in subdivision 1 of this subsection: (i) was under a COBRA continuation provision and the coverage under such provision was exhausted or (ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated; and

4. Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in clause (i) of subdivision 3 of this subsection or termination of coverage or employer contribution described in clause (ii) of subdivision 3 of this subsection.

K. If: (i) a health insurance issuer makes coverage available with respect to a dependent of an individual; (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and (iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer shall provide for a dependent special enrollment period described in subsection L during which the person (or, if not otherwise enrolled, the individual) may also be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

L. A dependent special enrollment period under this subsection shall be a period of not less than 30 days and shall begin on the later of:

1. The date dependent coverage is made available; or

2. The date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subsection K.

M. If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

2. In the case of a dependent's birth, as of the date of such birth; or

3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

N. A late enrollee may be excluded from coverage for up to 12 months or may have a preexisting condition limitation apply for up to 12 months; however, in no case shall a late enrollee be excluded from some or all coverage for more than 12 months. 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 30 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 30 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.

O. 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.

§ 38.2-3432.3. (Effective July 1, 2014) Limitation on preexisting condition exclusion period.

A. Subject to subsection B, a health insurer offering health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting limitation only if:

1. For group health insurance coverage, such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

2. For individual health insurance coverage, such exclusion relates to a condition that, during a 12-month 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 12 months immediately preceding the effective date of coverage;

3. Such exclusion extends for a period of not more than 12 months (or 12 months in the case of a late enrollee) after the enrollment date; and

4. The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

B. Exceptions:

1. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

3. A health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, except in the case of individual health insurance coverage for a person who is not considered an eligible individual, as defined in § 38.2-3430.2, in which case the health insurance issuer may impose a preexisting condition exclusion for a pregnancy existing on the effective date of coverage;

4. Subdivisions 1 and 2 of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage; and

5. Subdivision A 4 ~~of this section~~ shall not apply to health insurance coverage offered in the individual market on a "guarantee issue" basis without regard to health status including ~~open enrollment policies or contracts issued pursuant to § 38.2-4216.1 and~~ policies, contracts, certificates or evidences of coverage issued through a bona fide association or to students through school sponsored programs at a college or university unless the person is an eligible individual as defined in § 38.2-3430.2.

C. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

D. For purposes of subdivision B 4 and subsection C, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period under subsection C.

E. Methods of crediting coverage:

1. Except as otherwise provided under subdivision 2 of this subsection, a health insurance issuer offering group health coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period;

2. A health insurance issuer offering group health insurance coverage may elect to count a period of

creditable coverage based on coverage of benefits within each of several classes or categories of benefits rather than as provided under subdivision 1 of this subsection. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category;

3. In the case of an election with respect to a group plan under subdivision 2 of this subsection (whether or not health insurance coverage is provided in connection with such plan), the plan shall: (i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election and (ii) include in such statements a description of the effect of this election; and

4. In the case of an election under subdivision 2 of this subsection with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall: (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election and (ii) include in such statements a description of the effect of such election.

F. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection G or in such other manner as may be specified in federal regulations.

G. A health insurance issuer offering group health insurance coverage shall provide for certification of the period of creditable coverage:

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

2. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under such provision; and

3. At the request, or on behalf of, an individual made not later than 24 months after the date of cessation of the coverage described in subdivision 1 or 2 of this subsection, whichever is later. The certification under subdivision 1 of this subsection may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

H. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

I. In the case of an election described in subdivision E 2 by a health insurance issuer, if the health insurance issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subsection F:

1. Upon request of such health insurance issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting group insurance issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

2. Such entity may charge the requesting health insurance issuer for the reasonable cost of disclosing such information.

J. A health insurance issuer offering group health insurance coverage shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time;

3. The employee's or dependent's coverage described in subdivision 1 of this subsection: (i) was under a COBRA continuation provision and the coverage under such provision was exhausted or (ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated; and

4. Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subdivision 3 (i) of this subsection or termination of coverage or employer contribution described in subdivision 3 (ii) of this subsection.

K. If: (i) a health insurance issuer makes coverage available with respect to a dependent of an individual; (ii) the individual is a participant under the plan (or has met any waiting period applicable to

becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and (iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer shall provide for a dependent special enrollment period described in subsection L ~~of this section~~ during which the person (or, if not otherwise enrolled, the individual) may also be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

L. A dependent special enrollment period under this subsection shall be a period of not less than 30 days and shall begin on the later of:

1. The date dependent coverage is made available; or

2. The date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subsection K.

M. If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

2. In the case of a dependent's birth, as of the date of such birth; or

3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

N. A late enrollee may be excluded from coverage for up to 12 months or may have a preexisting condition limitation apply for up to 12 months; however, in no case shall a late enrollee be excluded from some or all coverage for more than 12 months. 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 30 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 30 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.

§ 38.2-3444. (Expires July 1, 2014) Preexisting condition exclusions for individuals under the age of 19.

A. Notwithstanding any provision of § 38.2-3432.3~~, 38.2-4216.1,~~ or any other section of this title to the contrary, a health carrier providing individual or group health insurance coverage shall not limit or exclude coverage for an individual under the age of 19 by imposing a preexisting condition exclusion on that individual.

B. Where a health carrier offers individual health insurance coverage that only covers individuals under the age of 19, such health carrier may offer coverage continuously throughout the year or during an open enrollment period in January and July of each calendar year.

C. During an open enrollment period, a health carrier shall not deny or unreasonably delay the issuance of a policy or refuse to issue a policy to an individual who is under the age of 19 on the basis of a preexisting condition.

D. Coverage shall be effective for an individual applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

E. Each health carrier shall provide a prominent public notice on its website and written notice to each covered person at least 90 days prior to the open enrollment period of the open enrollment rights for individuals under the age of 19 and provide information as to how an individual eligible for this open enrollment right may apply for coverage with the health carrier during an open enrollment period.

F. This section shall apply to any health carrier providing individual or group health insurance coverage, including a grandfathered plan for group health insurance coverage, but not including a

grandfathered plan for individual health insurance coverage.

§ 38.2-4229.1. Conversion to domestic mutual insurer.

A. Any domestic nonstock corporation subject to the provisions of this chapter that has the surplus required by § 38.2-1030 for domestic mutual insurers issuing policies without contingent liability may, at its option and without reincorporation, convert to a domestic mutual insurer by following the procedure set forth in this section.

B. Any nonstock corporation eligible to convert to a domestic mutual insurer under subsection A ~~of this section~~ may effect such conversion by amending its articles of incorporation to delete any reference to this chapter and to comply with the provisions of § 38.2-1002 relating to the articles of incorporation of a domestic mutual insurer. Upon the issuance of a certificate of amendment by the Commission, the conversion shall be effective, such nonstock corporation shall become subject to all of the provisions of this title relating to domestic mutual insurers, and ~~except as provided in subsection D of this section,~~ such nonstock corporation shall no longer be subject to the provisions of this chapter.

C. If any nonstock corporation converts from a health services plan organized under this chapter to a domestic mutual insurer, then at least ~~ninety~~ *90* days prior to the effective date of conversion, the nonstock corporation shall comply with § 38.2-316 by filing with the Commission copies of all policies of insurance that it proposes to issue after the effective date of conversion. All subscription contracts issued and outstanding as of the effective date of conversion shall remain in force in accordance with their terms until the expiration or termination of such contracts.

D. ~~Any nonstock corporation that offers an open enrollment program under § 38.2-4216.1 shall, directly or through a subsidiary, continue to offer such program notwithstanding its conversion to a domestic mutual insurer. If any such domestic mutual insurer converts to a stock insurer, it shall, directly or through a subsidiary, continue to offer such program notwithstanding its conversion to a stock insurer. No such insurer shall discontinue the open enrollment program required by § 38.2-4216.1 without first giving the Commission twenty-four months' prior written notice. For so long as the insurer continues to offer such open enrollment program, the license tax imposed on the direct gross premium income of the insurer and its subsidiaries from accident and sickness insurance shall be two and one-fourth percent (2.25%) on premium income from accident and sickness insurance issued to primary small employers as defined in § 38.2-3431 and three-fourths of one percent (.75%) on other premium income from accident and sickness insurance for taxable year 1997; and shall thereafter be three-fourths of one percent on premium income derived from individual accident and sickness insurance policies and from open enrollment contracts as defined in § 38.2-4216.1, and two and one-fourth percent on other premium income from accident and sickness insurance.~~

~~E.~~ No policy of accident and sickness insurance issued by a nonstock corporation after its conversion to a domestic mutual insurer shall deny the policyholder the right to assign his benefit, except that denial may be made where the benefit is ~~eighty~~ *80* percent of covered charges or greater.

§ 58.1-2501. Levy of license tax.

A. For the privilege of doing business in the Commonwealth, there is hereby levied on every insurance company defined in § 38.2-100 which issues policies or contracts for any kind of insurance classified and defined in §§ 38.2-102 through 38.2-134 and on every corporation which issues subscription contracts for any kind of plan classified and defined in §§ 38.2-4201 and 38.2-4501, an annual license tax as follows:

1. For any kind of insurance classified and defined in §§ 38.2-109 through 38.2-134 or Chapters 44 (§ 38.2-4400 et seq.) and 61 (§ 38.2-6100 et seq.) of Title 38.2, except workers' compensation insurance on which a premium tax is imposed under the provisions of § 65.2-1000, such company shall pay a tax of two and three-fourths percent of its subscriber fee income or direct gross premium income on such insurance for each taxable year through 1988. For taxable year 1989 and each taxable year thereafter, such company shall pay a tax of two and one-fourth percent of its subscriber fee income or direct gross premium income on such insurance~~.~~*;*

2. For policies or contracts for life insurance as defined in § 38.2-102, such company shall pay a tax of two and one-fourth percent of its direct gross premium income on such insurance. However, with respect to premiums paid for additional benefits in the event of death, dismemberment or loss of sight by accident or accidental means, or to provide a special surrender value, special benefit or an annuity in the event of total and permanent disability, the rate of tax shall be two and three-fourths percent for each taxable year beginning January 1, 1987, through December 31, 1988, and two and one-fourth percent for taxable year beginning January 1, 1989, and each taxable year thereafter~~.~~*;*

3. For policies or contracts providing industrial sick benefit insurance as defined in § 38.2-3544, such company shall pay a tax of one percent of its direct gross premium income on such insurance. No company, however, doing business on the legal reserve plan, shall be required to pay any licenses, fees or other taxes in excess of those required by this section on such part of its business as is industrial sick benefit insurance as defined in § 38.2-3544; but any such company doing business on the legal reserve

plan shall pay on all industrial sick benefit policies or contracts on which the sick benefit portion has been cancelled as provided in § 38.2-3546, or which provide a greater death benefit than $250 or a greater weekly indemnity than $10, and on all other life, accident and sickness insurance, the same license or other taxes as are required by this section.*; and*

4. For subscription contracts for any kind of plan classified and defined in § 38.2-4201 or § 38.2-4501, such corporation shall pay a tax of two and one-fourth percent of its direct gross subscriber fee income derived from subscription contracts issued to primary small groups as defined in § 38.2-3431 and three-fourths of one percent of its direct gross subscriber fee income derived from other subscription contracts for taxable year 1997. For each *of* taxable ~~year thereafter~~ *years 1998 through 2013*, such corporation shall pay a tax of three-fourths of one percent of its direct gross subscriber fee income derived from subscription contracts issued to individuals and from open enrollment contracts as defined in § 38.2-4216.1, and two and one-fourth percent of its direct gross subscriber fee income derived from other subscription contracts. *For each taxable year thereafter, such corporation shall pay a tax of two and one-fourth percent of its direct gross subscriber fee income derived from all subscription contracts.* The declaration of estimated tax pursuant to this subsection shall commence on or before April 15, 1988.

B. Notwithstanding any other provisions of this section, any domestic insurance company doing business solely in the Commonwealth which is purely mutual, has no capital stock and is not designed to accumulate profits for the benefit of or pay dividends to its members, and any domestic insurance company doing business solely in the Commonwealth, with a capital stock not exceeding $25,000 and which pays losses with assessments against its policyholders or members, shall pay an annual license tax of one percent of its direct gross premium income.

2. That § 38.2-4216.1 of the Code of Virginia, as it is currently effective and as it may become effective, is repealed.

3. That the provisions of this act shall become effective on January 1, 2014.