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SENATE BILL NO. 195

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Finance and Appropriations on February 2, 2022)

(Patrons Prior to Substitute—Senators Mason and Dunnavant [SB 549])

A BILL to amend and reenact §§ 38.2-508.5, 38.2-3420, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, and 38.2-3521.1 of the Code of Virginia and to amend the Code of Virginia by adding in Title 59.1 a chapter numbered 55, consisting of sections numbered 59.1-589 through 59.1-592, relating to group health benefit plans; sponsoring associations; formation of benefits consortium.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-508.5, 38.2-3420, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, and 38.2-3521.1 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 59.1 a chapter numbered 55, consisting of sections numbered 59.1-589 through 59.1-592, as follows:

§ 38.2-508.5. Re-underwriting individual under existing group or individual accident and sickness insurance policy prohibited; exceptions.

A. No premium increase, including a reduced premium increase in the form of a discount, may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such premium increase is determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

B. No reduction in benefits may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such reduction in benefits is determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

C. No modifications to contractual terms and conditions may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such modifications to contractual terms and conditions are determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

D. This section shall not prohibit adjustments to premium, rescission of, or amendments to the insurance contract in the following circumstances:

1. When an insurer learns of information subsequent to issuing the policy or certificate that was not disclosed in the underwriting process and that, had it been known, would have resulted in a higher premium level or denial of coverage. Any adjustment to premium or rescission of coverage made for this reason may be made only to extent that it would have been made had the information been disclosed in the application process, and shall not be imposed beyond any period of incontestability, or beyond any time period proscribing an insurer from asserting defenses based upon misstatements in applications, as otherwise may be provided by applicable law. Any such rescission shall be consistent with § 38.2-3430.3 regarding guaranteed availability.

2. When an insurer provides a lifestyle-based good health discount based upon an individual's adherence to a healthy lifestyle and this discount is not based upon a specific health condition or diagnosis.

3. When an insurer removes waivers or riders attached to the policy at issue that limit coverage for specific named pre-existing medical conditions.

E. For purposes of this section, re-underwriting means the reevaluation of any health-status-related factor of an individual for purposes of adjusting premiums, benefits or contractual terms as provided in subsections A, B, and C.

F. The provisions of this section shall not apply to individual health insurance coverage issued to members of a bona fide *sponsoring* association, as defined in subsection B of § 38.2-3431, where coverage is available to all members of the association and eligible dependents of such members without regard to any health-status-related factor.

G. 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.

§ 38.2-3420. Authority and jurisdiction of Commission; exception.

A. Except as provided in subsection ~~B~~ *C,* any person offering or providing coverage in the

Commonwealth for health care services, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Commission to the extent the person is not regulated by another agency of the Commonwealth, any subdivision of the Commonwealth, or the federal government relating to the offering or providing of coverage for health care services.

B. *As used in this subsection:*

"Health benefit plan" has the same meaning as described in § 38.2-3431.

"Self-funded multiple employer welfare arrangement" or "self-funded MEWA" means any multiple employer welfare arrangement that is not fully insured by a licensed insurance company. This term includes a benefit consortium established under Chapter 55 (§ 59.1-589 et seq.) of Title 59.1.

1. No self-funded multiple employer welfare arrangement shall issue health benefit plans in the Commonwealth until it has obtained a license pursuant to regulations promulgated by the Commission. No provision of this subsection shall authorize a self-funded MEWA domiciled outside of the Commonwealth to operate in the Commonwealth without obtaining a license pursuant to the regulations promulgated by the Commission.

2. Notwithstanding any other section of this title or Chapter 55 (§ 59.1-589 et seq.) of Title 59.1 to the contrary, all financial and solvency requirements imposed by provisions of this title upon domestic insurers shall apply to domestic self-funded MEWAs unless domestic self-funded MEWAs are otherwise specifically exempted. For the purposes of handling the rehabilitation, liquidation, or conservation of a domestic self-funded MEWA, the provisions of Chapter 15 (§ 38.2-1500 et seq.) shall apply.

3. Notwithstanding any other section of this title or Chapter 55 (§ 59.1-589 et seq.) of Title 59.1 to the contrary, any health benefit plan issued by a self-funded MEWA, including a trust, benefits consortium, or other arrangement, that covers one or more employees of one or more small employers shall (i) provide essential health benefits and cost-sharing requirements as set forth in § 38.2-3451; (ii) offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan; (iii) not limit or exclude coverage for an individual by imposing a preexisting condition exclusion on that individual pursuant to § 38.2-3444; (iv) not establish discriminatory rules based on health status related to eligibility or premium or contribution requirements as imposed on health carriers pursuant to § 38.2-3432.2; (v) meet the renewability standards set forth for health insurance issuers in § 38.2-3432.1; (vi) establish base rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all participant claims; and (vii) utilize each employer member's specific risk profile to determine premiums by actuarially adjusting above or below established base rates, and utilize either pooling or reinsurance of individual large claimants to reduce the adverse impact on any specific employer member's premiums.

4. The Commission shall have authority to adopt regulations applicable to self-funded MEWAs, whether domiciled inside or outside of the Commonwealth, including regulations addressing the self-funded MEWA's financial condition, solvency requirements, and insolvency plan and its exclusion, pursuant to § 59.1-574, from the Virginia Life, Accident and Sickness Insurance Guaranty Association established under Chapter 17 (§ 38.2-1700 et seq.).

C. Neither the provisions of this section nor any other provision of this title shall be construed to affect or apply to a multiple employer welfare arrangement (MEWA) ~~comprised~~ *composed* only of banks together with their plan-sponsoring organization, and their respective employees, provided the multiple employer welfare arrangement (i) is duly licensed as a MEWA by the insurance regulatory agency of a state contiguous to the Commonwealth, (ii) files with the Commission a copy of its certificate of authority or other proper license from the contiguous state, (iii) has no more than 500 Virginia residents who are employees of its member banks enrolled in or receiving accident and sickness benefits as insureds, members, enrollees, or subscribers of the MEWA, and (iv) is subject to solvency examination authority and reserve adequacy requirements determined by sound actuarial principles by such domiciliary contiguous state. For purposes of this subsection:

"Bank" means an institution that has or is eligible for insurance of deposits by the Federal Deposit Insurance Corporation.

"Plan-sponsoring organization" means an association that (i) sponsors a MEWA ~~comprised~~ *composed* only of banks; (ii) has been actively in existence for at least five years; (iii) has been formed and maintained in good faith for purposes other than obtaining insurance; (iv) does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee; (v) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members or individuals eligible for coverage through a member; (vi) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and (vii) meets such additional requirements as may be imposed under the laws of the Commonwealth, and includes any subsidiary of such an association.

§ 38.2-3431. Application of article; definitions.

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

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

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

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

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

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

B. For the purposes of this article:

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

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

1. Such period shall begin on the enrollment date.

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

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

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

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

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

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

"COBRA continuation provision" means any of the following:

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

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

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

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

the following:

1. A group health plan;

2. Health insurance coverage;

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

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

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

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

7. A state health benefits risk pool;

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

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

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

11. Individual health insurance coverage.

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

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

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

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

1. In accordance with the terms of such plan;

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

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

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

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

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

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

1. Benefits not subject to requirements of this article:

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

b. Coverage issued as a supplement to liability insurance;

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

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

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

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

a. Limited scope dental or vision benefits;

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

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

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

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

b. Hospital indemnity or other fixed indemnity insurance.

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

a. Medicare supplemental health insurance (as defined under section 1882 (g)(1) of the Social Security Act (42 U.S.C. § 1395ss (g)(1));

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

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

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

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

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

"Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

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

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

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

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

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

1. Health status;
2. Medical condition (including both physical and mental illnesses);
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability (including conditions arising out of acts of domestic violence); or
8. Disability.

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

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

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

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

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

1. The first period in which the individual is eligible to enroll under the plan; or

2. A special enrollment period as required pursuant to subsections J through M of § 38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. Transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Insurance covering medical care referred to in subdivisions 1 and 2.

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

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

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

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

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

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

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

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

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

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

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In determining whether a corporation or limited liability company employed an average of at least one individual during the preceding calendar year and employed at least one employee on the first day of the plan year, an individual who performed any service for remuneration under a contract of hire, written or oral, express or implied, for a (i) corporation of which the individual is a shareholder or an immediate family member of a shareholder or (ii) a limited liability company of which the individual is a member shall be deemed to be an employee of the corporation or the limited liability company, respectively. However, a health insurance issuer shall not be required to issue more than one group health plan for each employer identification number issued by the Internal Revenue Service for a business entity, without regard to the number of shareholders or members of such business entity. "Small employer" includes a self-employed individual.

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

"Sponsoring association" means a nonstock corporation formed under the Virginia Nonstock Corporation Act (§ 13.1-801 et seq.) that:

1. Has been formed and maintained in good faith for purposes other than obtaining or providing health benefits;

2. Does not condition membership in the sponsoring association on any factor relating to the health status of an individual, including an employee of an employer member of the sponsoring association or a dependent of such an employee;

3. Makes any health benefit plan available to all members regardless of any factor relating to the health status of such members or individuals eligible for coverage through another member;

4. Does not make any health benefit plan available to any person who is not a member of the association;

5. Makes available health plans or health benefit plans that meet the requirements for health benefit plans set forth in subdivision B 3 of § 38.2-3420;

6. Operates as a nonprofit entity under § 501(c)(5) or 501(c)(6) of the Internal Revenue Code;

7. Has been in active existence for at least five years; and

8. Meets such additional requirements as may be imposed under the laws of the Commonwealth.

"Sponsoring association" includes any wholly owned subsidiary of a sponsoring association.

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

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

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

§ 38.2-3432.1. Renewability.

A. Every health insurance issuer that offers health insurance coverage in the group market in this Commonwealth shall renew or continue in force such coverage with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, or contract holder, or where the health insurance issuer has not received timely premium payments;

2. When the health insurance issuer is ceasing to offer coverage in the small group market in accordance with subdivisions 9 and 10;

3. For fraud or misrepresentation by the employer, with respect to their coverage;

4. With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her 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 a health insurance issuer offers health insurance coverage in the group market through a network plan, and there is no longer an enrollee in connection with such plan who lives, resides, or works in the service area of the health insurance issuer (or in the area for which the health insurance issuer is authorized to do business) and, in the case of the group market, the health insurance issuer would deny enrollment with respect to such plan under the provisions of subdivision 9 or 10;

8. When health insurance coverage is made available in the group market only through one or more bona fide *sponsoring* associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this subdivision uniformly without regard to any health status related factor relating to any covered individual;

9. When a health insurance issuer decides to discontinue offering a particular type of group health insurance coverage in the group market in ~~this~~ *the* Commonwealth, coverage of such type may be discontinued by the health insurance issuer in accordance with the laws of ~~this~~ *the* Commonwealth in such market only if (i) the health insurance issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage; (ii) the health insurance issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in such market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under this subdivision, the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

10. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the group market in ~~this~~ *the* Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only in accordance with the laws of ~~this~~ *the* Commonwealth and if: (i) the health insurance issuer provides notice to the Commission and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and (ii) all health insurance issued or delivered for

issuance in ~~this~~ *the* Commonwealth in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed;

11. In the case of a discontinuation under subdivision 10 of this subsection in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market and ~~this~~ *the* Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed;

12. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan or health insurance issuer offering group health insurance coverage in the group market if, for coverage that is available in such market other than only through one or more bona fide *sponsoring* associations, such modification is consistent with the laws of ~~this~~ *the* Commonwealth and effective on a uniform basis among group health plans or health insurance issuers offering group health insurance coverage with that product; or

13. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

B. 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.

§ 38.2-3432.2. Availability.

A. If coverage is offered under this article in the small employer market:

1. Such coverage shall be offered and made available to all the eligible employees of every small employer and their dependents, including late enrollees, that apply for such coverage. No coverage may be offered only to certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status; and

2. All products that are approved for sale in the small group market that the health insurance issuer is actively marketing must be offered to all small employers, and the health insurance issuer must accept any employer that applies for any of those products. This subdivision shall not apply to health insurance coverage or products offered by a health insurance issuer if such coverage or product is made available in the small group market only through one or more bona fide *sponsoring* associations.

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

C. A health insurance issuer that offers health insurance coverage in a small group market through a network plan may:

1. Limit the employers that may apply for such coverage to those eligible individuals who live, work or reside in the service area for such network plan; and

2. Within the service area of such plan, deny such coverage to such employers if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

a. It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

b. It is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factors relating to such employees and dependents.

3. A health insurance issuer upon denying health insurance coverage in any service area in accordance with subdivision D 1, may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

D. A health insurance issuer may deny health insurance coverage in the small group market if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

1. It does not have the financial reserves necessary to underwrite additional coverage; and

2. It is applying this subdivision uniformly to all employers in the small group market in the Commonwealth consistent with the laws of ~~this~~ *the* Commonwealth and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

E. A health insurance issuer upon denying health insurance coverage in accordance with subsection D in the Commonwealth may not offer coverage in the small group market for a period of 180 days after the date such coverage is denied or until the health insurance issuer has demonstrated to the satisfaction of the Commission that the health insurance issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

F. Nothing in this article shall be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules in connection with a health benefit plan offered in the small group market. As used in this article, the term "employer contribution rule" means a

requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of eligible individuals and the term "group participation rule" means a requirement relating to the minimum number of eligible employees that must be enrolled in relation to a specified percentage or number of eligible employees. Any employer contribution rule or group participation rule shall be applied uniformly among small employers without reference to the size of the small employer group, health status of the small employer group, or other factors.

G. 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. 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, 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, 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 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 policies, contracts, certificates, or evidences of coverage issued through a bona fide *sponsoring* association or to students through school sponsored programs at an institution of higher education 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, 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. 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 (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 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, whichever is later. The certification under subdivision 1 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 (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 or termination of coverage or employer contribution described in clause (ii) of subdivision 3.

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.

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

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

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

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

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

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

B. A policy which is:

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

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

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

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

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

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

b. The premium for the policy shall be paid 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 funds contributed by insured debtors specifically for their insurance 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 may be payable to the creditor or any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of the insurance shall be payable to the insured or the estate of the insured.

6. Notwithstanding the preceding provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. 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.

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

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

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

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

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

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

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

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

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

a. Have at the outset a minimum of 100 persons;

b. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;

c. Have been in active existence for at least five years;

d. Have a constitution and bylaws ~~which~~ *that* provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees;

e. ~~Does not~~ *Not* condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

f. ~~Makes~~ *Make* health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

g. ~~Does not~~ *Not* make health insurance coverage offered through the association available other than in connection with a member of the association; and

h. ~~Meets~~ *Meet* such additional requirements as may be imposed under the laws of ~~this~~ *the* Commonwealth.

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

a. The policy may insure members of such association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

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

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

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

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

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

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

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

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

I. 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.

CHAPTER 55.

BENEFITS CONSORTIUM.

§ 59.1-589. Definitions.

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

"Benefits consortium" means a trust that is a self-funded MEWA, as defined in § 38.2-3420, and that complies with the conditions set forth in § 59.1-590.

"ERISA" means the federal Employee Retirement Income Security Act of 1974, P.L. 93-406, 88 Stat. 829, as amended.

"Health benefit plan" has the same meaning as in § 38.2-3431.

"Health plan" means an employee welfare benefit plan, within the meaning of ERISA § 3(1) that provides hospital, surgical, or medical expense benefits in the event of sickness or injury.

"Member" means a person that is part of a sponsoring association, that conducts business operations within the Commonwealth, and that employs individuals who reside in the Commonwealth.

"Sponsoring association" has the same meaning as in § 38.2-3431 and includes any wholly owned subsidiary of a sponsoring association.

"Trust" means a trust that (i) is established to accept and hold assets of a health benefit plan in trust in accordance with the terms of the written trust document for the sole purposes of providing medical, prescription drug, dental, and vision benefits and defraying reasonable administrative costs of providing health benefits under a health benefit plan and (ii) complies with the conditions set forth in § 59.1-590.

§ 59.1-590. Conditions for a benefits consortium.

A. This section does not apply to a multiple employer welfare arrangement (MEWA) that offers or provides health benefits plans that are fully insured by an insurer authorized to transact the business of health insurance in the Commonwealth.

B. A trust shall constitute a benefits consortium and shall be authorized to sell or offer to sell health benefit plans to members of a sponsoring association in accordance with the provisions of this chapter if all of the following conditions are satisfied:

1. The trust shall be subject to (i) ERISA and U.S. Department of Labor regulations applicable to multiple employer welfare arrangements and (ii) the authority of the U.S. Department of Labor to enforce such law and regulations;

2. A Form M-1, Report for Multiple Employer Welfare Arrangements (MEWAs), for the applicable plan year shall be filed with the U.S. Department of Labor identifying the arrangement among the trust, sponsoring association, and health benefit plans offered through the trust as a multiple employer welfare arrangement;

3. The trust's organizational documents shall:

a. Provide that the trust is sponsored by the sponsoring association;

b. State that the purpose of the trust is to provide medical, prescription drug, dental, and vision benefits to participating employees of the sponsoring association or its members, and the dependents of those employees, through health benefit plans;

c. Provide that the funds of the trust are to be used for the benefit of participating employees, and the dependents of those employees, through self-funding of claims, the purchase of reinsurance, or a combination thereof, as determined by the trustee, and for defraying reasonable expenses of administering and operating the trust and any health benefit plan;

d. Limit participation in health benefit plans to participating employees of the sponsoring association and its members;

e. Provide for a board of trustees, composed of no fewer than five trustees, that has complete fiscal control over the arrangement and is responsible for all operations of the arrangement. The trustees selected for the board shall be owners, partners, officers, directors, or employees of one or more employers in the arrangement. A trustee or director may not be an owner, officer, or employee of the administrator or service company of the arrangement. The board shall have the authority to approve applications of association members for participation in the arrangement and to contract with a licensed administrator or service company to administer the day-to-day affairs of the arrangement;

f. Provide for the election of trustees to the board of trustees; and

g. Require the trustees to discharge their duties with respect to the trust in accordance with the fiduciary duties defined in ERISA.

4. Five or more members shall participate in one or more health benefit plans;

5. The trust shall establish and maintain reserves determined in accordance with sound actuarial principles and in compliance with all financial and solvency requirements imposed upon domestic self-funded MEWAs;

6. The trust shall purchase and maintain policies of specific, aggregate, and terminal excess insurance with retention levels determined in accordance with sound actuarial principles from insurers licensed to transact the business of insurance in the Commonwealth;

7. The trust shall secure one or more guarantees or standby letters of credit that:

a. Guarantee the payment of claims under the health benefit plan in an aggregate amount not less than the amount of the trust's annual aggregate excess insurance retention level minus (i) the annual premium assessments for the health benefit plans and (ii) the trust's net assets, which amount shall be the net of the trust's reasonable estimate of incurred but not reported claims; and

b. Have been issued by a qualified United States financial institution, as such term is used in subdivision 2 c of § 38.2-1316.4.

8. The trust shall purchase and maintain commercially reasonable fiduciary liability insurance;

9. The trust shall purchase and maintain a bond that satisfies the requirements of ERISA;

10. The trust is audited annually by an independent certified public accountant; and

11. The trust does not include in its name the words "insurance," "insurer," "underwriter," "mutual," or any other word or term or combination of words or terms that is uniquely descriptive of an insurance company or insurance business unless the context of the remaining words or terms clearly indicates that the entity is not an insurance company and is not transacting the business of insurance.

§ 59.1-591. Additional requirements.

A. The board of trustees established pursuant to subsection B of § 59.1-590 shall (i) operate any health benefit plans in accordance with the fiduciary duties defined in ERISA and (ii) have the power to make and collect special assessments against members and, if any assessment is not timely paid, to enforce collection of such assessment.

B. Each member shall be liable for his allocated share of the liabilities of the sponsoring association under a health benefit plan as determined by the board of trustees.

C. Health benefit plan documents shall have the following statement printed on the first page in size 14-point boldface type:

"This coverage is not insurance and is not offered through an insurance company. This coverage is not required to comply with certain federal market requirements for health insurance, nor is it required to comply with certain state laws for health insurance. Each member shall be liable for his allocated share of the liabilities of the sponsoring association under the health benefit plan as determined by the board of trustees. This means that each member may be responsible for paying an additional sum if the annual premiums present a deficit of funds for the trust. The trust's financial documents shall be available for public inspection at (insert website of where sponsoring association trust documents are posted)."

§ 59.1-592. Exemptions; license tax.

Notwithstanding any other provision of law, a benefits consortium or sponsoring association, by virtue of its sponsorship of a benefits consortium or any benefits plan, shall not be subject to the following: (i) the provisions of Chapter 17 (§ 38.2-1700 et seq.) of Title 38.2 or any regulations adopted thereunder or (ii) any annual license tax levied pursuant to § 58.1-2501.