VIRGINIA ACTS OF ASSEMBLY -- 2023 SESSION

CHAPTER 514

An Act to amend and reenact § 38.2-3521.1 of the Code of Virginia, relating to association health plans; base rates based on employer member's risk profile.

[H 2201]

Approved March 26, 2023

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3521.1 of the Code of Virginia is amended and reenacted as follows:

§ 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, 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 that is:

1. Not subject to Chapter 37.1 (§ 38.2-3727 et seq.): 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, 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 that 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 from either 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, 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, 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.

1. The association or associations shall:

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

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

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

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

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

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

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

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

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

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

5. For a policy issued in the large group market and notwithstanding the provisions of § 38.2-3449, an insurer may (i) establish base rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all participant claims and (ii) utilize each employer member's specific risk profile to determine contribution rates for each individual employer member's share of the premium by actuarially adjusting above or below established base rates.

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, 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. Notwithstanding the provisions of subsection J, a policy issued to an association of real estate salespersons, as defined in § 54.1-2101, which association shall be deemed the policyholder, to insure members of such association, subject to the following requirements:

1. All of the members of such association shall be eligible for coverage. Members shall include (i) an employer member with at least one employee that is domiciled in the Commonwealth or (ii) a self-employed individual who (a) has an ownership right in a "trade or business," regardless of whether the trade or business is incorporated or unincorporated, (b) earns wages or self-employment income from the trade or business, and (c) works at least 20 hours a week or 80 hours a month providing personal services to the trade or business or earns income from the trade or business that at least equals the self-employed individual's cost of the health coverage.

2. The association shall (i) have at the outset a minimum of 25,000 members, (ii) have been organized and maintained in good faith for purposes other than that of obtaining insurance, (iii) have been in active existence for at least five years, and (iv) have a constitution and bylaws that provide that (a) the association hold regular meetings not less than annually to further purposes of the members, (b) the association collects dues or solicits contributions from members, and (c) the members have voting privileges and representation on the governing board and committees.

3. In no case shall membership in the association be conditioned on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee.

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

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

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

7. The policy issued to such an association shall (i) be considered a large group market plan subject to all coverage mandates applicable to a large group market plan offered in the Commonwealth and the large group market insurance regulations under the federal Public Health Service Act, P.L. 78-410, as amended; (ii) be subject to the group health plan coverage requirements under the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended; (iii) be prohibited from denying coverage under the policy on the basis of a preexisting condition as set forth in § 38.2-3444; (iv) be guaranteed issue and guaranteed renewable; (v) notwithstanding the provisions of subsection A of § 38.2-3451 providing that a large group market plan is not required to provide coverage for essential health benefits in a manner that exceeds the requirements of the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended, as of January 1, 2019, be subject to the requirements to provide essential health benefits and cost-sharing requirements as set forth in § 38.2-3451; and (vi) 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.

8. The insurer issuing such a policy shall (i) treat all of the members and employees of employer members who are enrolled in coverage under the policy as a single risk pool; (ii) set premiums on the basis of all of the collective group experience of the members and employees of employer members who are enrolled in coverage under the policy; (iii) be permitted to vary premiums by age, but such rate shall

not vary by more than four to one for adults; (iv) be prohibited from varying premiums on the basis of gender; (v) be prohibited from varying premiums on the basis of the health status of an individual employee of an employer member or a self-employed individual member; and (vi) not establish discriminatory rules based on the health status of an employer member, an individual employee of an employer member, or a self-employed individual for eligibility or contribution.

9. A policy that meets the requirements of subdivisions 7 and 8 shall be considered to be compliant with the large group market insurance regulations under the federal Public Health Service Act, P.L. 78-410, as amended, and, as such, the Commonwealth, through the regulation of such policy by the Commission, shall be considered to be substantially enforcing the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended, with regard to such policy. The Commission shall regulate the policy in a manner that is consistent with this subdivision. In any case in which a federal agency renders a decision that is contrary to the provisions of this subdivision, notwithstanding any other provision of law, the Attorney General may resolve any difference between federal law and the laws of the Commonwealth.

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

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

J. 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.