VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 38.2-3431, 38.2-3433, 38.2-4214, 38.2-4216.1, 38.2-4217, 38.2-4229.1, 38.2-4306, 38.2-4319, and 58.1-2501 of the Code of Virginia; to amend the Code of Virginia by adding in Chapter 34 of Title 38.2 an article numbered 4.1, consisting of sections numbered 38.2-3430.1 through 38.2-3430.10; by adding sections numbered 38.2-3432.1, 38.2-3432.2, and 38.2-3432.3; by adding in Article 5 of Chapter 34 of Title 38.2 sections numbered 38.2-3434 through 38.2-3437; and by adding in Chapter 43 of Title 38.2 sections numbered 38.2-4322 and 38.2-4323; and to repeal § 38.2-3432 of the Code of Virginia, relating to health insurance, implementing the provisions of P.L. 104-191, the Health Insurance Portability and Accountability Act.

[S 1112]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3431, 38.2-3433, 38.2-4214, 38.2-4216.1, 38.2-4217, 38.2-4229.1, 38.2-4306, 38.2-4319, and 58.1-2501 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Chapter 34 of Title 38.2 an article numbered 4.1, consisting of sections numbered 38.2-3430.1 through 38.2-3430.10; by adding sections numbered 38.2-3432.1, 38.2-3432.2, and 38.2-3432.3; by adding in Article 5 of Chapter 34 of Title 38.2 sections numbered 38.2-3434 through 38.2-3437; and by adding in Chapter 43 of Title 38.2 sections numbered 38.2-4322 and 38.2-4323 as follows:

Article 4.1.

Individual Health Insurance Coverage.

§ 38.2-3430.1. Application of article.

This article applies to individual health insurance coverage offered, sold, issued, or renewed in this Commonwealth, but shall not apply to any individual health insurance coverage for any of the "excepted benefits" defined in § 38.2-3431. In the event of conflict between the provisions in this article and other provisions of this title, the provisions of this article shall be controlling.

§ 38.2-3430.2. Definitions.

A. The terms defined in § 38.2-3431 that are used in this article shall have the meanings set forth in that section.

B. For purposes of this article:

"Eligible individual" means an individual: 1. (i) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is eighteen or more months, and (ii) whose most recent prior creditable coverage was under a group health plan, governmental plan or church plan or health insurance coverage offered in connection with any such plan;

2. Who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a state plan under Title XIX of such Act, or any successor program, and does not have other health insurance coverage;

3. With respect to whom the most recent coverage within the coverage period described in subdivision 1 was not terminated based on a factor described in subdivisions B 1 or B 2 of § 38.2-3430.7 relating to nonpayment of premiums or fraud;

4. If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage; and

5. Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

§ 38.2-3430.3. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

A. Guaranteed availability.

1. All eligible individuals shall be provided a choice of all individual health insurance coverage currently being offered by a health insurance issuer and the chosen coverage shall be issued.

2. Such coverage provided as required in subdivision A 1 shall not impose any preexisting condition exclusion with respect to such coverage.

B. Health insurance issuers are prohibited from imposing any limitations or exclusions based upon named conditions that apply to eligible individuals.

§ 38.2-3430.4. Special rules for network plans.

A health insurance issuer that offers health insurance coverage in the individual market may:

1. Limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan;

2. Within the service area of such plan, deny such coverage to such individuals if the health insurance issuer has demonstrated to the Commission that: (i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders, enrollees and enrollees covered under individual contracts; and (ii) it is applying this section uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals;

3. A health insurance issuer, upon denying health insurance coverage in any service area in accordance with subdivision A 2, may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

§ 38.2-3430.5. Application of financial capacity limits.

A. A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the health insurance issuer has demonstrated 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 section uniformly to all individuals in the individual market in the Commonwealth consistent with the laws of this Commonwealth and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

B. A health insurance issuer, upon denying individual health insurance coverage in any service area in accordance with subsection A, may not offer such coverage in the individual market within such service area 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.

§ 38.2-3430.6. Market requirements.

A. The provisions of § 38.2-3427 shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

B. A health insurance issuer offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

§ 38.2-3430.7. Renewability of individual health insurance coverage.

A. Except as provided in this section, a health insurance issuer that provides individual health insurance coverage shall renew or continue in force such coverage at the option of the individual.

B. A heath insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based on one or more of the following:

1. The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

2. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

3. The issuer is ceasing to offer coverage in the individual market in accordance with subsection C and applicable state law;

4. In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the health insurance issuer is authorized to do business but only if such coverage is terminated under this section uniformly without regard to any health status-related factor of covered individuals; or

5. In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this section uniformly without regard to any health status-related factor of covered individuals.

C. Requirements for uniform termination of coverage.

1. In any case in which a health insurance issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the health insurance issuer only if:

a. The health insurance issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage;

b. The health insurance issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being

offered by the health insurance issuer for individuals in such market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision 1 b of this subsection, the health insurance issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

2. Discontinuance of all coverage.

a. Subject to subdivision 1 c of this subsection, in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in the Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only if: (i) the health insurance issuer provides notice to the Commission and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and (ii) all health insurance issued or delivered for issuance in this Commonwealth in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.

b. In the case of discontinuation under subdivision 2 a of this subsection in the individual market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the individual market in this Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

D. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with the laws of this Commonwealth and effective on a uniform basis among all individuals with that policy form.

E. In applying this section in the case of health insurance coverage that is made available by health insurance issuers in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association of which the individual is a member.

§ 38.2-3430.8. Certification of coverage.

The provisions of subsections F through I of § 38.2-3432.3 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

§ 38.2-3430.9. Regulations establishing standards.

A. The Commission may adopt regulations to enable it to establish and administer such standards relating to the provisions of this article and Article 5 (§ 38.2-3431 et seq.) of this chapter as may be necessary to (i) implement the requirements of this article and (ii) assure that the Commonwealth's regulation of health insurance issuers is not preempted pursuant to P. L. 104-191 (The Health Insurance Portability & Accountability Act of 1996).

B. The Commission may revise or amend such regulations and may increase the scope of the regulations to the extent necessary to maintain federal approval of the Commonwealth's program for regulation of health insurance issuers pursuant to the requirements established by the United States Department of Health and Human Services.

C. The Commission shall annually advise the standing committees of the General Assembly having jurisdiction over insurance matters of revisions and amendments made pursuant to subsection B.

§ 38.2-3430.10. Effective date.

The provisions of this article shall be effective on July 1, 1997, with the exception of § 38.2-3430.3 which shall be effective on January 1, 1998.

Article 5.

~~Small Employer Market Provisions.~~

Group Market Reforms and Individual Coverage Offered to Employees of Small Employers.

§ 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 ~~or primary small employer~~ market *in this Commonwealth* shall be subject to the provisions of this article ~~if any of the following conditions are met:~~. *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 ~~small~~ employer;

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

3. The ~~small~~ employer has permitted payroll deduction for the covered individual or any portion of the premium is paid by the ~~small~~ employer; or

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

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a ~~small employer carrier~~ *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 ~~small employer carrier~~ *health insurance issuer* in establishing premium rates for applicable ~~health benefit plans~~ *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.

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

"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.

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

"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 XVII of the Social Security Act (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 regulations); or

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

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

"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.

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

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

"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; 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.

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

"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 fifty-one employees on business days during the preceding calendar year and who employs at least two employees 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 or through a health insurance issuer.

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

~~benefit plan.~~ *, 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. Amounts paid for transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Amounts paid for 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.

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

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

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

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

~~"Small employer" or "small employer market" means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed less than 100 eligible employees and not less than two unrelated eligible employees, the majority of whom are employed within this Commonwealth. A small employer market group includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a small employer shall continue to apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this section.~~

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

"Small employer" means in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first

day of the plan year.

"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 or through a health insurance issuer.

"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.

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

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

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

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

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

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

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

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

~~D.~~ *C.*The Commission shall adopt regulations establishing the essential and standard plans *for sale in the small employer market*. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. Every ~~small employer carrier~~ *health insurance issuer* shall, as a condition of transacting business in Virginia with ~~primary~~ small employers, offer to ~~primary~~ small employers ~~at least~~ the essential and standard plans. However, any regulation adopted by the Commission shall contain a provision requiring all ~~small employer carriers~~ *health insurance issuers* to offer an option permitting a ~~primary~~ small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a ~~primary~~ small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title. All ~~small employer carriers~~ *health insurance issuers* shall issue the plans to every ~~primary~~ small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and shall satisfy the following provisions:

1. Such plan may include cost containment features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians and other health care providers, subject to the limitations set forth in §§ 38.2-3407 and 38.2-4209 and Chapter 43 (§ 38.2-4300 et seq.) of this title; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, if a health maintenance organization is federally qualified, and of nonfederally qualified health maintenance organizations, if a health maintenance organization is not federally qualified. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for ~~small employer carriers~~ *health insurance issuers*.

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

3. ~~Within 180 days after the Commission's approval of essential and standard health benefit plans,~~

~~every small employer carrier~~ *Every health insurance issuer offering group health insurance coverage* shall, as a condition of transacting business in Virginia with ~~primary~~ small employers, offer and make available to ~~primary~~ small employers an essential and a standard health benefit plan.

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

~~5.~~ *4.* All essential and standard benefit plans issued to ~~primary~~ small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium. A ~~small employer carrier~~ *health insurance issuer* shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. Each rider, separate policy or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a ~~small employer carrier~~ *health insurance issuer*, disapprove the continued use by the ~~small employer carrier~~ *health insurance issuer* of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

~~6.~~ *5.* No ~~small employer carrier~~ *health insurance issuer offering group health insurance coverage* is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection:

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

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

A ~~small employer carrier~~ *health insurance issuer offering group health insurance coverage* that does not offer coverage pursuant to subdivision ~~6~~ *5* b may not offer coverage to small employers until the Commission determines that the ~~carrier~~ *health insurance issuer* is no longer impaired.

~~7.~~ *6.* Every ~~small employer carrier~~ *health insurance issuer offering group health insurance coverage* shall uniformly apply the provisions of subdivision ~~D 6~~ *C 5* of this section and shall fairly market the essential and standard health benefit plans to all ~~primary~~ small employers in their established geographic service area of the Commonwealth. A ~~small employer carrier~~ *health insurance issuer offering group health insurance coverage* that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the ~~carrier~~ *health insurance issuer* submits and the Commission approves a plan to fairly market to ~~their~~ *the health insurance issuer's* established geographic service area.

~~8.~~ *7.* No health maintenance organization is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection in the case of any of the following:

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

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

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

d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than ~~ninety-nine~~ *fifty* eligible employees until the later of 180 days after closure to new applications or the date on which the ~~carrier~~ *health maintenance organization* notifies the Commission that it has regained capacity to deliver services to small employers. In the case of a health maintenance organization doing

business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision ~~7~~ *6* of this subsection apply.

~~9.~~ *8.* In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for ~~carriers~~ *heath insurance issuers,* agents and third-party administrators, including requirements relating to the following:

a. Registration by each ~~carrier~~ *health insurance issuer offering group health insurance coverage* with the Commission of its intention to ~~be~~ ~~a~~ ~~small~~ ~~employer~~ ~~carrier~~ *offer health insurance coverage in the small group market* under this article;

b. Publication by the Commission of a list of all ~~small~~ ~~employer~~ ~~carriers~~ *health insurance issuers who offer coverage in the small group market,* including a potential requirement applicable to agents, third-party administrators, and ~~carriers~~ *health insurance issuers* that no health benefit plan may be sold to a small employer by a ~~carrier~~ *health insurance issuer* not so identified as a ~~small~~ ~~employer~~ ~~carrier~~ , *health insurance issuer in the small group market*;

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

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

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

§ 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 subsections 9 or 10;

8. When health insurance coverage is made available in the group market only through one or more bona fide 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 Commonwealth, coverage of such type may be discontinued by the health insurance issuer in accordance with the laws of this 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 Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only in accordance with the laws of this 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 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 9 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 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 associations, such modification is consistent with the laws of this Commonwealth and effective on a uniform basis among group health plans or health insurance issuers offering group health insurance coverage with that product;

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; or

14. Benefits and premiums which have been added by rider to the essential or standard benefit plans issued to small employers shall be renewable at the sole option of the health insurance issuer.

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

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 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 connection with group health plans in accordance with subsection D in the Commonwealth may not offer coverage in connection with group health plans 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.

§ 38.2-3432.3. Limitation on preexisting condition exclusion period.

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

1. 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 6-month period ending on the enrollment date;

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

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

B. Exceptions:

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

2. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-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; and

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

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 sixty-three-day period during all of which the individual was not covered under any creditable coverage.

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

E. Methods of crediting coverage:

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

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

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

4. In the case of an election under subdivision 2 of this subsection with respect to health insurance

coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall: (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election; and (ii) include in such statements a description of the effect of such election.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

K. If: (i) a health insurance issuer makes coverage available with respect to a dependent of an individual; (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and (iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer shall provide for a dependent special enrollment period described in subdivision J 2 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 thirty 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 subdivision J 3.

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.

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

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

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

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

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

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

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

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

3. Provisions affecting any preexisting conditions provision.

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

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

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

§ 38.2-3434. Disclosure of information.

Any health insurance issuer offering health insurance coverage to a employer shall make a reasonable disclosure of the availability of information to such an employer, as part of its solicitation and sales materials, and upon request of such an employer, information concerning: (i) the provisions of such coverage concerning the health insurance issuer's right to change premium rates and the factors that may affect changes in premium rates; (ii) the provisions of such coverage relating to renewability of coverage; (iii) the provisions of such coverage relating to any preexisting condition exclusion; and (iv) the benefits and premiums available under all health insurance coverage for which the employer is qualified.

A health insurance issuer is not required under this article to disclose any information that is proprietary and trade secret information.

§ 38.2-3435. Exclusions.

The provisions of this article shall not apply to:

A. Any health insurance issuer offering group health insurance coverage for any plan year if, on the first day of such plan year, such plan has less than two participants who are current employees.

B. Any nonfederal governmental plan which is a group health plan who elects not to be bound by these requirements. The election shall apply: (i) for a single specified plan year; or (ii) in the case of a plan provided pursuant to collective bargaining agreement for the term of such agreement.

1. An election under this subsection may be extended through subsequent elections.

2. Under such an election, the plan shall provide for: (i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the act and consequences of such election and (ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with subsections G and H of § 38.2-3432.3.

C. Any health insurance issuer offering group health insurance coverage for any of the excepted benefits.

§ 38.2-3436. Eligibility to enroll.

A. A health insurance issuer offering group health insurance coverage, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the health status-related factors.

B. The provisions of this section shall not be construed:

1. To require a group health insurance coverage to provide particular benefits other than those provided under the terms of such plan or coverage; or

2. To prevent a health insurance issuer offering group health insurance coverage from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage rules for eligibility to enroll under a plan which includes rules defining any applicable waiting periods for such enrollment.

C. A health insurance issuer offering group health insurance coverage, may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

D. Nothing in subsection C shall be construed:

1. To restrict the amount that an employee may be charged for coverage under a group health plan or group health insurance coverage; or

2. To prevent a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

§ 38.2-3437. Rules used to determine group size.

A. All employers treated as a single employer under subsections (b), (c), (m), or (o) of § 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

B. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large group employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

C. Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

§ 38.2-4214. Application of certain provisions of law. — No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3409, 38.2-3411 through 38.2-3419.1, ~~38.2-3431, 38.2-3432, 38.2-3500,~~ *38.2-3430.1 through 38.2-3437*, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4216.1. Open enrollment.

A. A nonstock corporation licensed under this chapter shall make available to citizens of the Commonwealth an open enrollment program under the terms set forth in this section.

B. As used in this section, the term:

"Comprehensive accident and sickness contracts" means contracts conforming to the requirements of subsection E which are issued to provide basic hospital and medical-surgical coverage. ~~Group comprehensive accident and sickness contracts must include provisions allowing individuals who leave such groups to convert to an individual policy providing an adequate level of coverage as determined by the Commission pursuant to subsection E.~~

"Open enrollment contracts" means comprehensive accident and sickness contracts issued pursuant to an open enrollment program by a nonstock corporation licensed pursuant to this chapter providing coverage to individuals ~~and members of any group of forty-nine or fewer enrolled members, including multi-group, master-group or association-type contracts providing such coverage to individuals and members of organizations with forty-nine or fewer enrolled members~~.

C. Each nonstock corporation's open enrollment program shall provide for the issuance of open enrollment contracts without imposition by the nonstock corporation of underwriting criteria whereby coverage is denied or subject to cancellation or nonrenewal, in whole or in part because of~~:~~ ~~(i)~~ any individual's age, health or medical history, or employment status or, if employed, industry or job classification~~; or (ii) in the case of any group included within the definition of "open enrollment contracts," because of the industry or job classification of the group, or the age, medical or health history, or insurability of any member of such group, including dependents~~. The open enrollment program shall make open enrollment contracts available to any ~~group included in the definition of "open enrollment contracts" which is located in, and to any~~ individual residing in~~,~~ the nonstock corporation's service area within the Commonwealth; ~~provided,~~ however, ~~that~~ this subsection shall not require, and no person shall otherwise indicate, that open enrollment contracts are available to any individual who is an employee of an employer which provides, in whole or in part, hospitalization or other health coverage to its employees. Each nonstock corporation's open enrollment program shall make open enrollment contracts available on a year-round basis. The subscription charge for contracts issued pursuant to an open enrollment program shall be reasonable in relation to the benefits and deductibles provided, as determined by the Commission.

D. Each nonstock corporation must prominently advertise the availability of its open enrollment contracts at least twelve times annually in a newspaper or newspapers of general circulation throughout its service area in Virginia. The content and format of such advertising shall be generally approved by the Commission.

E. The Commission may prescribe minimum standards to govern the contents of comprehensive accident and sickness contracts issued pursuant to this section. Such minimum standards shall ensure that such contracts provide health benefit coverage for a comprehensive range of health care needs without qualifying exclusions that fail to protect the subscriber under normal circumstances. Such standards shall ensure that the option of obtaining comprehensive major medical coverage is made available to all individuals ~~and groups~~ included within the definition of "open enrollment contracts" and shall allow for reasonable co-payment provisions, a range of deductibles and a range of coverages available to the consumer. Preexisting conditions may not be excluded from coverage under such contracts; however, waiting periods of up to twelve months for coverage of preexisting conditions shall be allowed. In addition, the Commission may prescribe reasonable minimum standards in order to govern the contents of policies issued to individuals who have converted from group comprehensive accident and sickness contracts to individual coverage because of termination of the individual's eligibility for group coverage.

F. If a nonstock corporation licensed under this chapter elects to discontinue its open enrollment program provided under this section, it may do so only after giving written notice to the Commission of at least twenty-four months in advance of the effective date of termination. Upon termination of the program, the nonstock corporation shall be subject to the license tax provisions of subdivision 1 of subsection A of § 58.1-2501.

G. In addition, a nonstock corporation licensed under this chapter shall provide other public services to the community including health-related educational support and training for those subscribers who, based upon such educational support and training, may experience a lesser need for health-related care and expense.

§ 38.2-4217. Reports.

A. In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file on a quarterly basis any additional reports, exhibits or statements the Commission considers necessary to furnish full information concerning the condition, solvency, experience, transactions or affairs of the nonstock corporation. The Commission shall establish deadlines for submitting any additional reports, exhibits or statements. The Commission may require verification by any officers of the nonstock corporation the Commission designates.

B. In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file annually, on or before June 1, an annual statement, signed by two of its

principal officers subject to § 38.2-1304, showing:

1. The number of Virginia subscribers by the following type of contract or its equivalent:

a. Individual, open enrollment;

~~b. Small group, open enrollment;~~

~~c.~~ *b.* Medicare, extended, under 65 disabled;

~~d. Associations;~~

~~e. Community-rated groups of under 50 members;~~ and

~~f.~~ *c.* Individual conversion subscribers~~;~~*.*

2. The subscriber income and benefit payments in the aggregate for the types of contracts listed above subject to specific breakdown by type of contract as requested by the Commission; and

3. Expenditures for providing public services, in addition to open enrollment, to the community.

§ 38.2-4229.1. Conversion to domestic mutual insurer.

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

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

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

D. Any nonstock corporation that offers an open enrollment program under § 38.2-4216.1 shall, directly or through a subsidiary, continue to offer such program notwithstanding its conversion to a domestic mutual insurer. If any such domestic mutual insurer converts to a stock insurer, it shall, directly or through a subsidiary, continue to offer such program notwithstanding its conversion to a stock insurer. No such insurer shall discontinue the open enrollment program required by § 38.2-4216.1 without first giving the Commission twenty-four months' prior written notice. For so long as the insurer continues to offer such open enrollment program, the license tax imposed on the direct gross premium income of the insurer and its subsidiaries from accident and sickness insurance shall be ~~three-fourths of one percent (.75%) for taxable year 1994 and shall thereafter be~~ two and one-fourth percent (2.25%) on premium income from accident and sickness insurance issued to primary small employers as defined in § 38.2-3431 and three-fourths of one percent (.75%) on other premium income from accident and sickness insurance *for taxable year 1997; and shall thereafter be three-fourths of one percent on premium income derived from individual accident and sickness insurance policies and from open enrollment contracts as defined in § 38.2-4216.1, and two and one-fourth percent on other premium income from accident and sickness insurance*.

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

§ 38.2-4306. Evidence of coverage and charges for health care services.

A. 1. Each subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the Commission, subject to the provisions of subsection C of this section.

3. No evidence of coverage shall contain provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.

4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

a. The health care services and any insurance or other benefits to which the enrollee is entitled under the health care plan;

b. Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature;

c. Where and in what manner information is available as to how services may be obtained;

d. The total amount of payment for health care services and any indemnity or service benefits that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory for group certificates;

e. A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee;

f. A list of providers and a description of the service area which shall be provided with the evidence of coverage, if such information is not given to the subscriber at the time of enrollment; and

g. The right of subscribers covered under a group contract to convert their coverages to an individual contract issued by the health maintenance organization.

B. 1. No schedule of charges or amendment to the schedule of charges for enrollee coverage for health care services may be used in conjunction with any health care plan until a copy of the schedule, or its amendment, has been filed with the Commission.

2. The charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applying to an enrollee *in a group health plan* shall not be individually determined based on the status of his health. A certification on the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information. This certification shall be prepared by a qualified actuary or other qualified professional approved by the Commission.

C. The Commission shall, within a reasonable period, approve any form if the requirements of subsection A of this section are met. It shall be unlawful to issue a form until approved. If the Commission disapproves a filing, it shall notify the filer. The Commission shall specify the reasons for its disapproval in the notice. A written request for a hearing on the disapproval may be made to the Commission within thirty days after notice of the disapproval. If the Commission does not disapprove any form within thirty days of the filing of such form, it shall be deemed approved unless the filer is notified in writing that the waiting period is extended by the Commission for an additional thirty days. Filing of the form means actual receipt by the Commission.

D. The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing made under this section.

§ 38.2-4319. Statutory construction and relationship to other laws. — A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3419.1, ~~38.2-3431,~~ ~~38.2-3432,~~ ~~38.2-3433,~~ *38.2-3430.1 through 38.2-3437,* 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 54 (§ 38.2-5400 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

§ 38.2-4322. Affiliation period.

A. A health maintenance organization which offers health insurance coverage in connection with a group health plan or group health insurance coverage and which does not impose any preexisting condition exclusion allowed under § 38.2-3432.3, with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if:

1. Such period is applied uniformly without regard to any health status-related factors; and

2. Such period does not exceed two months (or three months in the case of a late enrollee).

B. An affiliation period as described in subsection A shall begin on the enrollment date.

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

D. Defined terms as set forth in § 38.2-3431 which are used in this chapter shall have the same

meaning here that they have in Chapter 34.

§ 38.2-4323. Alternative methods.

A health maintenance organization may use alternative methods to an affiliation period to address adverse selection provided that they are approved by the Commission prior to their use.

§ 58.1-2501. Levy of license tax.

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

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

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

3. For policies or contracts providing industrial sick benefit insurance as defined in § 38.2-3544, such company shall pay a tax of one percent of its direct gross premium income on such insurance. No company, however, doing business on the legal reserve plan, shall be required to pay any licenses, fees or other taxes in excess of those required by this section on such part of its business as is industrial sick benefit insurance as defined in § 38.2-3544; but any such company doing business on the legal reserve plan shall pay on all industrial sick benefit policies or contracts on which the sick benefit portion has been cancelled as provided in § 38.2-3546, or which provide a greater death benefit than $250 or a greater weekly indemnity than $10, and on all other life, accident and sickness insurance, the same license or other taxes as are required by this section.

4. For subscription contracts for any kind of plan classified and defined in § 38.2-4201 or § 38.2-4501, such corporation shall pay a tax of ~~0.75 of one percent of its direct gross subscriber fee income for each taxable year beginning on and after January 1, 1988.~~ *two and one-fourth percent of its direct gross subscriber fee income derived from subscription contracts issued to primary small groups as defined in § 38.2-3431 and three-fourths of one percent of its direct gross subscriber fee income derived from other subscription contracts for taxable year 1997. For each taxable year thereafter, such corporation shall pay a tax of three-fourths of one percent of its direct gross subscriber fee income derived from subscription contracts issued to individuals and from open enrollment contracts as defined in § 38.2-4216.1, and two and one-fourth percent of its direct gross subscriber fee income derived from other subscription contracts.* The declaration of estimated tax pursuant to this subsection shall commence on or before April 15, 1988.

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

2. That § 38.2-3432 of the Code of Virginia is repealed.

3. That the Bureau of Insurance within the State Corporation Commission, in cooperation with the Joint Commission on Health Care, monitor the impact of the provisions of this act on the Commonwealth's health insurance marketplace. In monitoring the impact of this act, the State Corporation Commission shall: (i) review the federal regulations that will be promulgated to implement P.L. 104-191 (The Health Insurance Portability and Accountability Act), and determine whether any changes to this act are required by federal regulations adopted pursuant to P.L. 104-191; (ii) monitor the impact of the guaranteed issue requirements in the individual market and evaluate any specific concerns regarding such requirements identified and documented to the satisfaction of the State Corporation Commission by health insurance issuers; and (iii) recommend to the Governor and the 1998 Session of the General Assembly any revisions, corrections or improvements to the provisions of this act that would require the enactment of additional

1155 legislation.