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SENATE BILL NO. 1181

Offered January 20, 1997

A BILL to amend and reenact §§ 38.2-100, 38.2-508.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3503, 38.2-3514, 38.2-3518, 38.2-4214, 38.2-4216.1 and 38.2-4319 of the Code of Virginia, to amend the Code of Virginia by adding in Article 1 in Chapter 34 of Title 38.2 sections numbered 38.2-3407.12 and 38.2-3407.13, and to repeal §§ 38.2-3514.1, 38.2-3520 and 38.2-3531, relating to accident and sickness insurance; preexisting conditions; community rating.

Patron—Edwards

Referred to the Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-100, 38.2-508.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3503, 38.2-3514, 38.2-3518, 38.2-4214, 38.2-4216.1 and 38.2-4319 of the Code of Virginia are amended and reenacted, that the Code of Virginia is amended by adding in Article 1 in Chapter 34 of Title 38.2 sections numbered 38.2-3407.12 and 38.2-3407.13 as follows:

§ 38.2-100. Definitions.

As used in this title:

"Alien company" means a company incorporated or organized under the laws of any country other than the United States.

"Commission" means the State Corporation Commission.

"Commissioner" or "Commissioner of Insurance" means the administrative or executive officer of the division or bureau of the Commission established to administer the insurance laws of this Commonwealth.

"Community rating" means a rating mechanism in which an insurer charges the same rate for the same policy period to all of the insureds in a defined geographic community. There shall be no adjustments to the rates for age grouping, gender, health status, duration of coverage, industry classification, claims experience, or other rating factors which might be used. The community rate may vary based on single coverage, two-person coverage, or family coverage. Different insurers may have different community rates for the same product, if they offer the same product.

"Company" means any association, aggregate of individuals, business, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Domestic company" means a company incorporated or organized under the laws of this Commonwealth.

"Foreign company" means a company incorporated or organized under the laws of the United States, or of any state other than this Commonwealth.

"Health services plan" means any arrangement for offering or administering health services or similar or related services by a corporation licensed under Chapter 42 (§ 38.2-4200 et seq.) of this title.

"Insurance company" means any company engaged in the business of making contracts of insurance.

"Insurance transaction," "insurance business," and "business of insurance" include solicitation, negotiations preliminary to execution, execution of an insurance contract, and the transaction of matters subsequent to execution of the contract and arising out of it.

"Insurer" means an insurance company.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendment of 1965, as amended.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of 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 genetic information.

"Rate" or "rates" means any rate of premium, policy fee, membership fee or any other charge made by an insurer for or in connection with a contract or policy of insurance. The terms "rate" or "rates" shall not include a membership fee paid to become a member of an organization or association, one of the benefits of which is the purchasing of insurance coverage.

"Rate service organization" means any organization or person, other than a joint underwriting association under § 38.2-1915 or any employee of an insurer including those insurers under common control or management, who assists insurers in ratemaking or filing by:

(a) Collecting, compiling, and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or

(c) Advising about rate questions, except as an attorney giving legal advice.

"State" means any commonwealth, state, territory, district or insular possession of the United States.

"Surplus to policyholders" means the excess of total admitted assets over the liabilities of an insurer, and shall be the sum of all capital and surplus accounts, including any voluntary reserves, minus any impairment of all capital and surplus accounts.Without otherwise limiting the meaning of or defining the following terms, "insurance" shall include fidelity and suretyship, and "insurance contracts" or "insurance policies" shall include contracts of fidelity, indemnity, guaranty and suretyship.

§ 38.2-508.1. Unfair discrimination; members of the armed forces.

A. No person shall refuse to issue or refuse to continue a life insurance policy on the life of any member of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard due to (i) their status as a member of any such military organization or (ii) their duty assignment while a member of any such military organization.

B. In circumstances where an individual's or family member's coverage under a group life or group health insurance policy or contract was terminated due to such individual's status as a member of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard, no person shall refuse to reinstate such coverage, regardless of continuation, renewal, reissue or replacement of the group insurance policy, upon the occurrence of the individual's return to eligibility status under the policy or contract. Such reinstated coverage shall not contain any ~~new~~ preexisting condition or other exclusions or limitations ~~except that the remainder of a preexisting condition requirement that was not satisfied prior to termination of the individual's coverage resulting from such military status may be applied once the individual returns and coverage under the group policy is reinstated~~.

§ 38.2-3407.12. Exclusions for preexisting conditions not permitted.

No (i) 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, (ii) corporation providing individual or group accident and sickness subscription contracts, or (iii) health maintenance organization providing a health care plan for health care services shall issue any policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1,1997, containing any preexisting condition exclusion.

§ 38.2-3407.13. Community rating required.

Every new or renewal premium rate for any individual or group policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1,1997, by (i) an 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, (ii) a corporation providing individual or group accident and sickness subscription contracts, or (iii) a health maintenance organization providing a health care plan for health care services shall be based on community rating.

§ 38.2-3431. Small employer market.

A. 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 coverage to the small employer or primary small employer market 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 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 in establishing premium rates for applicable health benefit plans.

"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.

"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 combined claims experience for all groups within its primary small employer market.

"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.

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

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

"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; 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.

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

"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.

"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 employer and eligible employees as a condition of coverage from a carrier, 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 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.

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~~ *Neither a late enrollee nor his dependents shall be excluded from coverage for any period because of a preexisting condition.*

D. The Commission shall adopt regulations establishing the essential and standard plans. 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 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 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 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.

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 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. 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 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, disapprove the continued use by the small employer carrier of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

6. No small employer carrier 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 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 being declared an impaired insurer.

A small employer carrier that does not offer coverage pursuant to subdivision 6 b of this subsection may not offer coverage to small employers until the Commission determines that the carrier is no longer impaired.

7. Every small employer carrier shall uniformly apply the provisions of subdivision D 6 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 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 submits and the Commission approves a plan to fairly market to their established geographic service area.

8. 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 eligible employees until the later of 180 days after closure to new applications or the date on which the carrier 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 of this subsection apply.

9. 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, agents and third-party administrators, including requirements relating to the following:

a. Registration by each carrier with the Commission of its intention to be a small employer carrier under this article;

b. Publication by the Commission of a list of all small employer carriers, including a potential requirement applicable to agents, third-party administrators, and carriers that no health benefit plan may be sold to a small employer by a carrier not so identified as a small employer carrier;

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 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 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 that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

§ 38.2-3432. Small employer market subject to certain provisions.

A. ~~Every~~ *No* individual or group policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth or providing benefits to or on behalf of a small employer pursuant to this article ~~is subject to the following provisions:~~ *shall contain preexisting conditions provisions.*

~~1. Except in the case of a late enrollee, any preexisting conditions provision may not limit, deny or exclude coverage for a period beyond twelve months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage or as to a pregnancy existing on the effective date of coverage.~~

~~2. A condition which would otherwise be covered pursuant to subdivision A 1 may not be excluded from coverage.~~

~~3. In determining whether a preexisting conditions provision applies to an insured, all coverage shall credit the time the person was covered under previous coverage provided under: (i) Medicare, Medicaid, CHAMPUS, the Indian Health Service Program or any other similar publicly sponsored program, (ii) a group health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the essential health benefit plan, or (iii) an individual health insurance policy, including coverage issued by a health maintenance organization, health services plan or fraternal benefit society, that provides benefits similar to or exceeding the benefits provided under the essential health benefit plan if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, whether or not the new coverage is provided by a different employer, exclusive of any applicable waiting period under such coverage.~~

B. Coverage shall be renewable with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, contract holder or enrollee;

2. For abuse or misuse of a provider network provision;

3. For fraud or misrepresentation of the policyholder, contract holder or enrollee, with respect to their coverage;

4. When the employer is no longer actively engaged in the business in which it was engaged on the effective date of the 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 primary small employer new business ceases to be written by an insurer in the small employer market, provided that the following conditions are satisfied:

a. Notice of the decision to cease writing new business in the primary small employer market is provided to the Commission and to either the policyholder, contract holder, enrollee or employer;

b. Writing new business in the primary small employer market in this Commonwealth shall be prohibited for a period of three years from the date of notice to the Commission pursuant to this subdivision. In the case of a health maintenance organization which ceases to do new business in the small employer market in one service area of the Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in that service area;

c. When a small employer carrier ceases to write new business and renew business in the primary small employer market, it may continue to participate in the market of small employers which are not primary small employers if it complies with the provisions of this article applicable to the small employer market. Nothing in this provision shall prohibit a small employer carrier from writing and renewing business in the primary small employer market if it has ceased writing and renewing business to small employers which are not primary small employers; and

d. Health benefit plans subject to this article shall not be canceled for 180 days after the date of the notice required under subdivision 7 a of this subsection and for that business of a small employer carrier which remains in force, any small employer carrier that ceases to write new business in the small employer market shall continue to be governed by this article with respect to business conducted under this article; or

8. Benefits and premiums which have been added by rider to the essential or standard benefit plans issued to primary small employers shall be renewable at the sole option of the small employer carrier.

C. If coverage is offered under this article, such coverage shall be offered and made available to all of the eligible employees of a small employer and their dependents. 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; provided that small employer groups having policies, contracts or plans in effect prior to July 1, 1994, which charge different premiums to their employees or dependents because of health status, may, upon written request to the small employer carrier at the time of any renewal of such policy, contract or plan, continue to have different premiums charged to their employees and dependents because of health status; however, this ability to charge different premiums because of health status shall expire on July 1, 1997.

D. 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.

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

§ 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 to a primary small employer not currently enrolled with that same employer carrier shall be based on a community rate ~~subject to the following conditions:~~

~~1. A small employer carrier 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 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 may deviate from the community rate filed by the small employer carrier 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 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 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~~ *provisions* relating to renewability of policies and contracts~~; and~~

~~3. Provisions affecting any preexisting conditions provision~~.

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

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

§ 38.2-3503. Required accident and sickness policy provisions.

Except as provided in § 38.2-3505, each individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall contain the provisions specified in this section using the same words which appear in this section. An insurer may substitute corresponding provisions of different wording approved by the Commission that are in each instance not less favorable in any respect to the insured or the beneficiary. These provisions shall be preceded individually by the caption "REQUIRED PROVISIONS" or by such appropriate individual or group captions or subcaptions as the Commission may approve.

1. Provision 1:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

2. Provision 2:

TIME LIMIT ON CERTAIN DEFENSES: (a) Misstatements in the application: After two years from the date of this policy, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability (as defined in the policy) that starts after the two-year period.

Provision 2 shall not be construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subdivisions 1, 2, 3, 4 and 5 of § 38.2-3504 in the event of misstatement with respect to age, occupation or other insurance.

Instead of Provision 2, a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (i) until at least age fifty or, (ii) for a policy issued after age forty-four, for at least five years from its date of issue, may contain the following provision, from which the clause in parentheses may be omitted at the insurer's option:

INCONTESTABLE:

(a) Misstatements in the application: After this policy has been in force for two years during the Insured's lifetime (excluding any period during which the Insured is disabled), the Company cannot contest the statements in the application.

~~PREEXISTING CONDITIONS:~~

~~(b) No claim for loss incurred or disability (as defined in the policy) that starts after one year from the date of issue of this policy will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.~~

3. Provision 3:

GRACE PERIOD: This policy has a .... day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following .... days. During the grace period the policy shall continue in force.

In Provision 3 a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "a" and "day," and between "following" and "days."

A policy that contains a cancellation provision may add, at the end of Provision 3: "subject to the right of the Company to cancel in accordance with the cancellation provision."

A policy in which the insurer reserves the right to refuse any renewal shall have, in Provision 3, the following sentence:

The grace period will not apply if, at least .... days before the premium due date, the Company has delivered or has mailed to the Insured's last address shown in the Company's records written notice of the Company's intent not to renew this policy.

In the above sentence a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "least" and "days."

4. Provision 4:

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the Company or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the policy. If the Company or its agent requires an application for reinstatement, the Insured will be given a conditional receipt for the premium. If the application is approved the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Company has previously written the Insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than ten days after such date. In all other respects the rights of the Insured and the Company will remain the same, subject to any provisions noted or attached to the reinstated policy. Any premiums the Company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than sixty days prior to the date of reinstatement.

The last sentence of Provision 4 may be omitted from any policy that the Insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least age fifty, or (ii) for a policy issued after age forty-four, for at least five years from its effective date.

5. Provision 5:

NOTICE OF CLAIM: Written notice of claim must be given within twenty days after a covered loss starts or as soon as reasonably possible. The notice can be given to the Company at ..... (insert the location of such office as the insurer may designate for the purpose), or to the Company's agent. Notice should include the name of the Insured, and Claimant if other than the Insured, and the policy number.

Optional paragraph: If the Insured has a disability for which benefits may be payable for at least two years, at least once in every six months after the Insured has given notice of claim, the Insured must give the Company notice that the disability has continued. The Insured need not do this if legally incapacitated. The first six months after any filing of proof by the Insured or any payment or denial of a

claim by the Company will not be counted in applying this provision. If the Insured delays in giving this notice, the Insured's right to any benefits for the six months before the date the Insured gives notice will not be impaired.

6. Provision 6:

CLAIM FORMS: When the Company receives the notice of claim, it will send the Claimant forms for filing proof of loss. If these forms are not given to the Claimant within fifteen days after the giving of such notice, the Claimant shall meet the proof of loss requirements by giving the Company a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

7. Provision 7:

PROOFS OF LOSS: If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the Company within ninety days after the end of each period for which the Company is liable. For any other loss, written proof must be given within ninety days after such loss. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. Provision 8:

TIME OF PAYMENT OF CLAIMS: After receiving written proof of loss, the Company will pay .... (Insert period for payment which must not be less frequently than monthly) all benefits then due for .... (Insert type of loss). Benefits for any other loss covered by this policy will be paid as soon as the Company receives proper written proof.

9. Provision 9:

PAYMENT OF CLAIMS: Benefits will be paid to the Insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or the Insured's estate.

Optional paragraph: If benefits are payable to the Insured's estate or a beneficiary who cannot execute a valid release, the Company can pay benefits up to $ .... (insert an amount which shall not exceed $2,000), to someone related to the Insured or beneficiary by blood or by marriage whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any payment made in good faith.

Optional paragraph: The Company may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless the Insured directs otherwise in writing by the time proofs of loss are filed. The Company cannot require that the services be rendered by a particular health care services provider.

10. Provision 10:

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company at its own expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

11. Provision 11:

LEGAL ACTIONS: No legal action may be brought to recover on this policy within sixty days after written proof of loss has been given as required by this policy. No legal action may be brought after three years from the time written proof of loss is required to be given.

12. Provision 12:

CHANGE OF BENEFICIARY: The Insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

38.2-3514. When liability not to be denied because of preexisting disease, physical impairment or defect.

No insurer that has delivered or issued for delivery in this Commonwealth an accident and sickness insurance policy pursuant to the provisions of this article shall deny liability on any claim otherwise covered under such policy because of the existence of a disease or physical impairment or defect, congenital or otherwise, at the time of the making of the application for such policy~~, unless it is shown that the applicant knew or might reasonably have been expected to know of such disease, impairment or defect~~.

§ 38.2-3518. Standards for policy provisions.

A. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations to establish specific standards, including standards of full and fair disclosure, for the sale of individual accident and sickness insurance policies. These rules and regulations shall be in addition to and in accordance with applicable laws of this Commonwealth, including Chapter 34 (§ 38.2-3400 et seq.) and Articles 1 (§ 38.2-3500 et seq.) and 2 (§ 38.2-3516 et seq.) of this chapter which may cover but shall

not be limited to:

1. Terms of renewability;

2. Initial and subsequent conditions of eligibility;

3. Nonduplication of coverage provisions;

4. Coverage of dependents;

5. Coverage of persons eligible for Medicare by reason of age;

~~6. Preexisting conditions;~~

~~7~~*6*. Termination of insurance;

~~8~~*7*. Probationary periods;

~~9~~*8*. Limitations;

~~10~~*9*. Exceptions;

~~11~~*10*. Reductions;

~~12~~*11*. Elimination periods;

~~13~~*12*. Requirements for replacement;

~~14~~*13*. Recurrent conditions; and

~~15~~*14*. Definition of terms including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable, and noncancellable.

For the purposes of this article, licensed health care practitioners, to the extent required by law, shall be deemed physicians.

B. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute that in the opinion of the Commission are unjust, unfair, or unfairly discriminatory to the policyowner, beneficiary, or any person insured under the policy.

§ 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, *38.2-3407.12, 38.2-3407.13*, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, ~~38.2-3514.1,~~ 38.2-3514.2, 38.2-3516 through ~~38.2-3520~~ *38.2-3519* 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.

§ 38.2-4319. 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, *38.2-3407.12*, *38.2-3407.13*, 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, 38.2-3500, ~~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.

2. That §§ 38.2-3514.1, 38.2-3520 and 38.2-3531 of the Code of Virginia are repealed.