

## VIRGINIA ACTS OF ASSEMBLY — CHAPTER

*An Act to amend and reenact §§ 38.2-3430.2, 38.2-3430.4, 38.2-3430.6, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, 38.2-3435, 38.2-3514.2 and 38.2-3531 of the Code of Virginia, relating to health insurance; conformity with the Health Insurance Portability Act.*

[H 781]

Approved

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 38.2-3430.2, 38.2-3430.4, 38.2-3430.6, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, 38.2-3435, 38.2-3514.2 and 38.2-3531 of the Code of Virginia are amended and reenacted as follows:**

§ 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 subdivision 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.

*For the purposes of determining the aggregate of the periods of creditable coverage under subdivision B 1 (i) of this section, 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, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage or was not serving a waiting period for coverage under a group health plan, or for group health insurance coverage or was in an affiliation period.*

§ 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 *eligible* 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.

§ 38.2-3430.6. Market requirements.

A. The provisions of ~~§ 38.2-3427~~ 38.2-3430.3 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.

ENROLLED

HB781ER

§ 38.2-3431. Application of article; definitions.

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

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

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

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

3. The employer has permitted payroll deduction for the covered individual or any portion of the premium is paid by the 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 health insurance issuer is in compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer in establishing premium rates for applicable insurance coverage.

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

1. Such period shall begin on the enrollment date.

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

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

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

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

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

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

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

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

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

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

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

"COBRA continuation provision" means any of the following:

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

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

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

"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 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~~ XVIII 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 *federal* 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 C of this section.

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

"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

179 Security Act (42 U.S.C. § 1395ss (g) (1));

180 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code  
181 (10 U.S.C. § 1071 et seq.); and

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

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

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

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

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

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

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

209 "Health insurance issuer" means an insurance company, or insurance organization (including a health  
210 maintenance organization) which is licensed to engage in the business of insurance in this  
211 Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within  
212 the meaning of section 514 (b) (2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C.  
213 § 1144 (b) (2)). Such term does not include a group health plan.

214 "Health maintenance organization" means:

- 215 1. A federally qualified health maintenance organization;
- 216 2. An organization recognized under the laws of this Commonwealth as a health maintenance  
217 organization; or
- 218 3. A similar organization regulated under the laws of this Commonwealth for solvency in the same  
219 manner and to the same extent as such a health maintenance organization.

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

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

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

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

236 "Large employer" means in connection with a group health plan or health insurance coverage with  
237 respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one  
238 employees on business days during the preceding calendar year and who employs at least two employees  
239 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, 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.

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

"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 health insurance issuer and are assumed to be in effect.

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

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least 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. *If an employee or dependent enrolls during a special enrollment*

period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such enrollment is not a waiting period.

C. The 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. The Commission shall modify such regulations as necessary to incorporate any revisions to the essential and standard plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits pursuant to § 9-298. Every health insurance issuer shall, as a condition of transacting business in Virginia with small employers, offer to small employers the essential and standard plans, *subject to the provisions of § 38.2-3432.2*. However, any regulation adopted by the Commission shall contain a provision requiring all health insurance issuers to offer an option permitting a 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 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 health insurance issuers shall issue the plans to every 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 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. Every health insurance issuer offering group health insurance coverage shall, as a condition of transacting business in Virginia with small employers, offer and make available to small employers an essential and a standard health benefit plan, *subject to the provisions of § 38.2-3432.2*.

4. All essential and standard benefit plans issued to 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 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 health insurance issuer, disapprove the continued use by the 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.

5. No 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 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 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 health insurance issuer being declared an impaired insurer.

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

6. Every health insurance issuer offering group health insurance coverage shall uniformly apply the

provisions of subdivision C 5 of this section and shall fairly market the essential and standard health benefit plans to all small employers in their established geographic service area of the Commonwealth. A 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 health insurance issuer submits and the Commission approves a plan to fairly market to the health insurance issuer's established geographic service area.

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 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 fifty eligible employees until the later of 180 days after closure to new applications or the date on which the 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 6 of this subsection apply.

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 health insurance issuers, agents and third-party administrators, including requirements relating to the following:

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

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

9. All essential and standard health benefits plans contracts delivered, issued for delivery, reissued, renewed, or extended in this Commonwealth on or after July 1, 1997, shall include coverage for 365 days of inpatient hospitalization for each covered individual during a twelve-month period. If coverage under the essential or standard health benefits plan terminates while a covered person is hospitalized, the inpatient hospital benefits shall continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided or (ii) the day the covered person is no longer hospitalized as an inpatient.

§ 38.2-3432.1. Renewability.

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

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

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

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

4. With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission;

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

8. When health insurance coverage is made available in the group market only through one or more bona fide 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 10 of this subsection in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market and this 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. *in the small employer market:*

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

2. All products that are approved for sale in the small group market that the health insurance issuer is actively marketing must be offered to all small employers, and the health insurance issuer must accept any employer that applies for any of those products.

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 ~~six~~-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 subdivision 1 or 2 of this subsection, whichever is later. The certification under subdivision 1 of this subsection may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

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

I. In the case of an election described in subdivision E 2 by a health insurance issuer, if the health

insurance issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subsection F:

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

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

J. A health insurance issuer offering group health insurance coverage, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage 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~~ subsection L of this subsection 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~~ subsection K.

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

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

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

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

*N. A late enrollee may be excluded from coverage for up to eighteen months or may have a preexisting condition limitation apply for up to eighteen 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.*

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

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

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

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

676 § 38.2-3435. Exclusions.

677 The provisions of this article shall not apply to:

678 A. 1. Any health insurance issuer offering group health insurance coverage for any plan year if, on  
679 the first day of such plan year, such plan has less than two participants who are current employees; or

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

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

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

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

690 § 38.2-3514.2. Renewability of coverage.

691 A. Every individual policy, subscription contract or plan delivered, issued for delivery or renewal in  
692 this Commonwealth providing benefits to or on behalf of an individual shall provide for the renewability  
693 of such coverage at the sole option of the insured, policyholder, subscriber, or enrollee. The insurer,  
694 health services plan or health maintenance organization issuing such policy, subscription contract or plan  
695 shall be permitted to refuse to renew the policy, subscription contract or plan only for one or more of  
696 the following reasons:

697 1. Nonpayment of the required premiums by the insured, policyholder, subscriber, or enrollee, or  
698 such individual's representative;

699 2. In the event that the policy, subscription contract or plan contains a provision requiring the use of  
700 network providers, a documented pattern of abuse or misuse of such provision by the insured,  
701 policyholder, subscriber, or enrollee, continuing for a period of no less than two years;

702 3. Subject to the time limits contained in subdivision 2 of § 38.2-3503 or in regulations adopted by  
703 the Commission governing the practices of health maintenance organizations, for fraud or material  
704 misrepresentation by the individual, with respect to his application for coverage;

705 4. Eligibility of an individual insured for Medicare, provided that such coverage may not terminate  
706 with respect to other individuals insured under the same policy, subscription contract or plan and who  
707 are not eligible for Medicare; and

708 5. The insured, subscriber, or enrollee has not maintained a legal residence in the service area of the  
709 insurer, health services plan or health maintenance organization for a period of at least six months.

710 B. This section shall not apply to the following insurance policies, subscription contracts or plans:

711 1. Short-term travel;

712 2. Accident-only;

713 3. Disability income;

714 4. Limited or specified disease contracts;

715 5. Long-term care insurance; and

716 6. Short-term nonrenewable policies or contracts of not more than six months' duration which are  
717 subject to no medical underwriting or minimal underwriting; and

718 7. Individual health insurance coverage as defined in subsection B of § 38.2-3431.

719 § 38.2-3531. Additional exclusions and limitations.

720 A. Each group accident and sickness insurance policy shall contain a provision specifying all  
721 additional exclusions or limitations applicable under the policy for any disease or physical condition of a  
722 person, not otherwise excluded from the person's coverage by name or specific description effective on  
723 the date of the person's loss, which existed prior to the effective date of the person's coverage under the  
724 policy.

725 B. Any such exclusion or limitation may only apply to a disease or physical condition for which  
726 medical advice or treatment was received by the person during the twelve months prior to the effective  
727 date of the person's coverage. The exclusion or limitation shall not apply to loss incurred or disability

728 commencing after the earlier of (i) the end of a continuous period of twelve months commencing on or  
729 after the effective date of the person's coverage during which the person receives no medical advice or  
730 treatment in connection with the disease or physical condition, or (ii) the end of the two-year period  
731 commencing on the effective date of the person's coverage.

732 *C. This section shall not apply to group accident and sickness policies providing hospital, medical*  
733 *and surgical or major medical coverage on an expense incurred basis to an employer's employees and*  
734 *their dependents.*

**ENROLLED**

HB781ER