ANNUAL REPORT OF

THE JOINT COMMISSION ON HEALTH CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 29

COMMONWEALTH OF VIRGINIA
RICHMOND
1997

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

Senator Stanley C. Walker
Chairman

Jane Norwood Kusiak
Executive Director

June 2, 1997

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TO: The Honorable George F. Allen, Governor of Virginia
and Members of the General Assembly

Pursuant to the provisions of the Code of Virginia (Title 9, Chapter 38, §§9-311 through 9-316) establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 1996.

This 1996 annual report includes a summary of the Joint Commission's 1996 activities and legislative recommendations to the 1997 General Assembly and an overview of health care issues facing Virginia and the nation. Copies of the legislation sponsored by the Joint Commission and passed by the 1997 General Assembly also are included.

In addition to this annual report, a separate report was published as a House or Senate document for each study the Joint Commission conducted pursuant to a joint study resolution. The document numbers of the individual study reports are identified on page 5.

Sincerely,

Stanley C. Walker
Chairman

Jane Norwood Kusiak
Executive Director

JOINT COMMISSION ON HEALTH CARE

Chairman
The Honorable Stanley C. Walker
Vice Chairman
The Honorable Kenneth R. Melvin

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
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The Honorable Jane H. Woods
The Honorable Thomas G. Baker, Jr.
The Honorable David G. Brickley
The Honorable Julia A. Connally
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable George H. Heilig, Jr.
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Robert C. Metcalf

JOINT COMMISSION ON HEALTH CARE

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Director

Jane Norwood Kusiak

Senior Health Policy Analyst

Patrick W. Finnerty

Office Manager

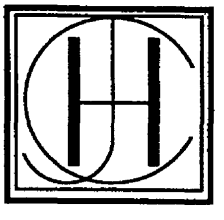
Mamie V. White

Access to the Internet

The Joint Commission's home page on the Internet is located at:
http://legis.state.va.us/jchc/jchchome.htm

Acknowledgements

The Joint Commission extends its sincere appreciation to the Office of the Clerk of the Senate, the Office of the Clerk of the House of Delegates, the Division of Legislative Services, and the Division of Legislative Automated Systems for their assistance and support throughout 1996. We would also like to thank Sandra Johnson Bailey for her editorial assistance in the preparation of this document.



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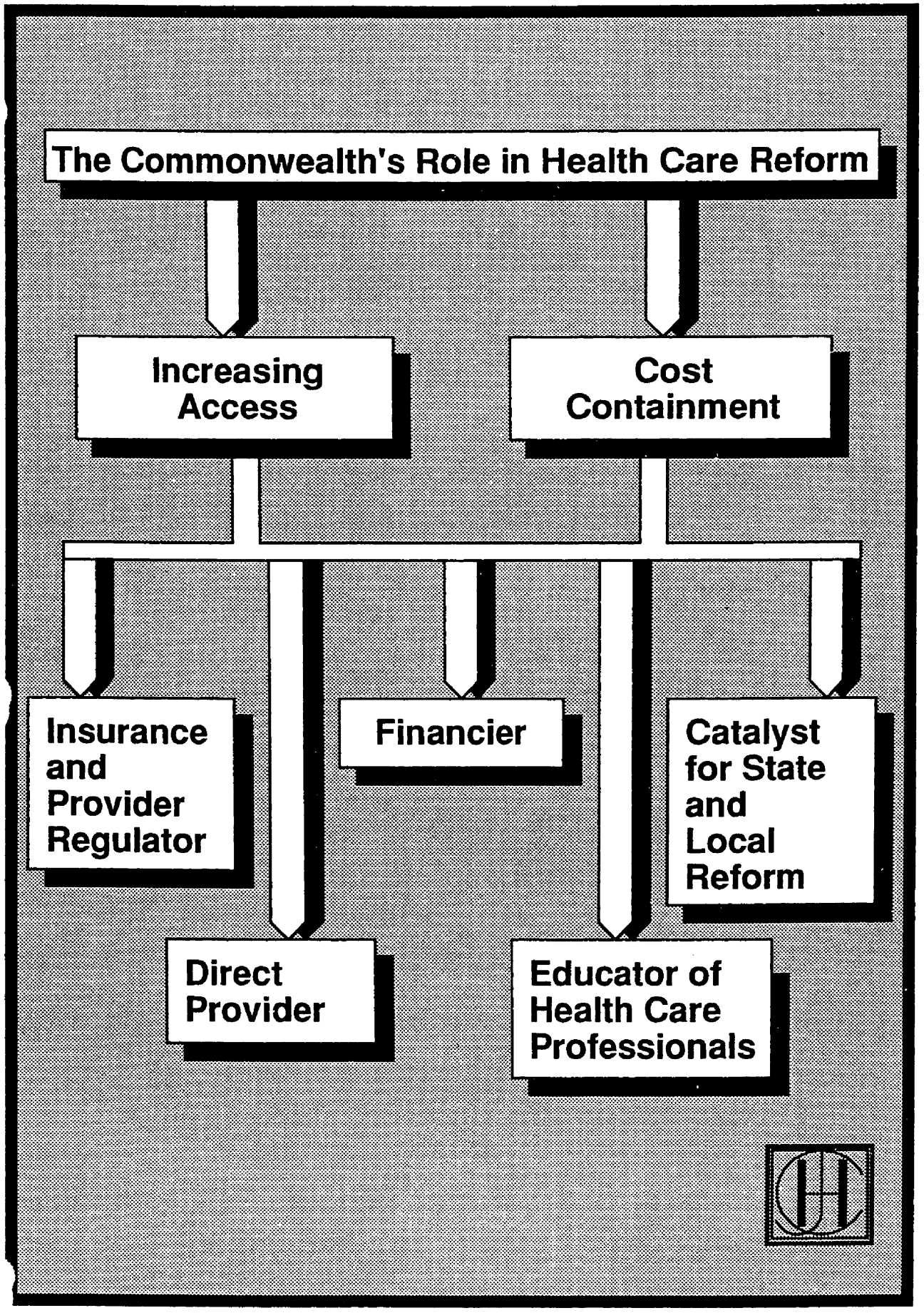

The Commonwealth's Role in Health Care Reform
Increasing Access
Cost Containment
Insurance and Provider Regulator
Financier
Catalyst for State and Local Reform
Direct Provider
Educator of Health Care Professionals

I. SUMMARY OF 1996 ACTIVITIES AND RELATED 1997 GENERAL ASSEMBLY ACTIONS

AUTHORITY FOR STUDY

The Joint Commission on Health Care was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032. This sixteen-member legislative commission, with a separately staffed agency, continues the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session).

1996 JOINT COMMISSION ACTIVITIES

The Joint Commission held seven meetings in 1996, as well as one additional meeting in January, 1997, prior to the 1997 Session of the General Assembly. All meetings were held at the General Assembly Building in Richmond. In addition to the agenda items identified below, monthly staff reports were presented at each meeting.

April 29th Meeting

At the April 29th meeting, the final status of the Joint Commission's 1996 legislation, as well as the current status of Joint Commission on Health Care initiatives, were reviewed. Additionally, the workplan for 1996 was presented and reviewed.

June 3rd Meeting

The June 3rd meeting included a staff report on potential abuses in independent living arrangements. Also, a workplan for the Joint Commission's study on whether health maintenance organizations (HMOs) should be required to offer "point-of-service" products was presented. A panel of experts reacted to the work plan. The panelists were Kim S. Barnes, Executive Director, Richmond Area Business Group on Health; Thomas G. Goddard, Regional General Counsel of NYLCare and Vice President of the Virginia Association of HMOs; Robert E. Hurley, Ph.D., Associate Professor, Department of Health Administration, Virginia Commonwealth University; Mark E. Rubin, Attorney at Law, Shuford,

Rubin & Gibney, P.C.; and Gordon R. Trapnell, F.S.A., M.A.A.A., President and Chief Actuary of Actuarial Research Corporation.

July 1st Meeting

During the July 1st meeting, election of a new Chairman and Vice Chairman of the Joint Commission was held. Senator Stanley C. Walker was elected as Chairman, and Delegate Kenneth R. Melvin was elected as Vice-Chairman.

Also during the July 1st meeting, the workplan for a Joint Commission study on the appropriateness of the certificate of public need (COPN) program, particularly as it relates to ambulatory surgery centers, was presented. A panel of experts discussed the workplan. The panelists were: George Barker, Associate Director, Health Systems Agency of Northern Virginia; John T. Brennan, Jr., Attorney at Law, Michaels, Wishner and Bonner, P.C.; Paul E. Parker, Director, Office of Resources Development, Virginia Department of Health; Louis F. Rossiter, Ph.D., Professor, Health Economics, Department of Health Administration, Virginia Commonwealth University; and Katharine M. Webb, Senior Vice President, Virginia Hospital & Healthcare Association.

The July 1st meeting also included an overview of the workplan for the Department of Health's study of the COPN program and how it relates to adult care residences. A panel of long-term care industry representatives discussed the workplan. The panelists included Mary Lynne Bailey, Vice President of Legal and Government Affairs, Virginia Health Care Association; Cindi A. Bowling, Project Manager, Adult Care Residences, Department of Medical Assistance Services; Sandy Harless, Chairperson of Legislative Committee, Assisted Living Facilities Association of America; Marcia A. Melton, Director of Legislative Services, Virginia Association of Nonprofit Homes for the Aging; and Michael Osorio, Executive Director, Virginia Association of Homes for Adults.

August 26th Meeting

The August 26th meeting included a staff report on the status of group and individual health insurance reforms in the Commonwealth. Randolph L. Gordon, M.D., M.P.H., Commissioner of Health, and Joseph M. Teefey, Director of the Department of Medical Assistance Services, provided an update on the Commonwealth's nursing home inspection process. A study on statutory exemptions and regulatory policy for PACE (Program for All-Inclusive Care for the Elderly) and Pre-PACE sights was

presented by Joseph Teefey, Steven A. Gold, President of Sentara Life Care, and Victoria Savoy, Chief Financial Auditor for the Financial Regulation Division of the Bureau of Insurance. Lastly, a staff presentation on the Joint Commission's study of the Commonwealth's role in overseeing the managed care industry was presented.

September 30th Meeting

At the September 30th meeting, the Joint Commission's new home page on the *Internet* was demonstrated. Also, a presentation on the Area Health Education Centers' (AHEC) strategic planning process and legislative proposals was provided by B. Jeanette Lancaster, Ph.D., R.N., FAAN, Chair of the Statewide AHEC Board and Dean of the University of Virginia School of Nursing. A status report on the Medallion II program was provided by Thomas E. McGraw, Director, Division of Program Delivery Systems, Department of Medical Assistance Services and Jennifer Hill Brockman, Director of Communications, Virginia Health Quality Center.

Also at the September meeting, a staff report on the Joint Commission's study of the various entities receiving state funds or having responsibilities for health care policy and regulations was presented. During the afternoon, a forum on aging and long-term care issues was held.

October 24th Meeting

The October 24th meeting included a briefing by John P. Gavin, President of Virginia Health Information, Inc. (VHI), on VHI's strategic plan for health care cost and quality data initiatives. Staff reports were presented on two Joint Commission studies. The first study analyzed the appropriateness of the certificate of public need (COPN) program, and whether ambulatory surgery centers should be subject to COPN review. The second study examined whether HMOs should be required to offer a "point-of-service" product. Paul E. Parker, Director of the Office of Resources Development within the Department of Health, presented a study on whether adult care residences (ACRs) should be subject to COPN review. Lastly, Health Commissioner Randolph L. Gordon, M.D., M.P.H., presented his five-year action plan for improving access to care for underserved areas and populations.

December 11th Meeting

During the December 11th meeting, Deborah D. Oswalt, Executive Director of the Virginia Health Care Foundation, presented the results of a recent survey on the health insurance status of Virginians. Staff presented an overview of Virginia's proposed response to the federal health insurance reforms contained in the Health Insurance Portability and Accountability Act passed by Congress in August, 1996. The meeting also included a staff report on the impact of Medicaid managed care programs on durable medical equipment companies and pharmacy services. Staff also presented an overview of each of the various issues studied by the Joint Commission throughout 1996, as well as potential legislation to be introduced during the 1997 Session of the General Assembly.

January 6, 1997 Meeting

At the January 6, 1997 meeting, staff reviewed the public comments received on the Joint Commission's draft legislative proposals and recommended changes to certain proposals based on the public comments. Final decisions regarding proposed 1997 legislation were made.

INDIVIDUAL STUDY REPORTS PUBLISHED BY THE JOINT COMMISSION ON HEALTH CARE

The Joint Commission conducted numerous studies throughout 1996. Prior to 1994, the Joint Commission incorporated the written reports from each study into the annual report. However, since 1994, the Joint Commission has prepared a separate report on each study conducted pursuant to a legislative mandate (i.e., a bill or study resolution). These reports, called "issue briefs," were presented to the Joint Commission at its monthly meetings.

Copies of each issue brief were distributed to persons attending the meeting at which the study was presented to the Joint Commission, as well as other interested parties who requested a copy. Public comments were received on each issue brief and presented to the Joint Commission at the next monthly meeting. Following the public comment period, each issue brief was finalized and printed as either a House or Senate Document. Figure 1 identifies each of the Joint Commission's 1996 studies which were printed as separate documents.

Figure 1

1996 Individual Study Reports Published by the Joint Commission on Health Care

Name of Study	Authority for Study	House/Senate Document
Potential Abuses in Independent Living Arrangements	HJR 637 (1995)	House Document 21
Reforms in Virginia's Individual Health Insurance Market	HB 1026	House Document 27
Exemptions and Regulatory Policy for PACE and Pre-PACE Projects	HB 1130	House Document 28
Review of Certificate of Public Need Program	HB 1302	House Document 82
Impact of Legislative Proposals on Managed Care/"Point-of-Service" Mandate	HB 1393/ HJR 231	House Document 79
Impact of Medicaid Managed Care on Durable Medical Equipment and Pharmacy Services	SJR 62	Senate Document 25
Role of the Commonwealth in Overseeing Managed Care	SJR 67	Senate Document 7
Various Entities Receiving State Funds or Having Responsibility for Health Care Policy/ Regulation	SJR 104	Senate Document 8

NOTE: Except as noted, all joint resolution and bill numbers are from the 1996 General Assembly Session. All House/Senate Document numbers are 1997 document numbers.

1997 LEGISLATIVE PROPOSALS

As a result of the work completed by the Joint Commission during 1996, a package of legislative proposals was introduced and approved during the 1997 Session of the General Assembly. The following paragraphs identify each legislative proposal. A copy of each bill and resolution approved by the General Assembly is provided in Appendix A with the page numbers identified below.

Bills

SB 1034 Provides clear statutory authority for the Commissioner of Health to develop and direct the state's trauma system and its component parts. This legislation emanated from a study of this issue published as 1996 Senate Document 23. (Appendix A, page 1)

SB 1102/ HB 2784 Enact revisions to certain insurance laws to facilitate the development and appropriate oversight of PACE and Pre-PACE program sites. This legislation emanated from a study of this issue published as 1997 House Document 28. (Appendix A, pages 3 and 28)

SB 1112/ HB 2887 Enact revisions to various insurance laws (individual and group markets) to comply with the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. These companion bills also adjust the requirements and tax provisions of Virginia's "open enrollment" program to reflect the small group (2-50) market reforms contained within the HIPAA. (Appendix A, pages 5 and 39)

Related Legislative Action: HB 2682 allocated the savings which were generated by this bill for the creation of the Virginia Children's Medical Security Insurance Plan.

HB 2477 Requires the Commissioner of Health to conduct an annual review of the Certificate of Public Need program. This legislation emanated from a study of this issue published as 1997 House Document 82. (Appendix A, page 27)

HB 2785 Requires the Commissioner of Health to review the quality of health care services provided by health maintenance

organizations (HMOs), and requires the Bureau of Insurance to examine HMOs' complaint systems. This legislation amends §38.2-305(B) such that the required notice on insurers' policy forms regarding the Bureau of Insurance's complaint review process also must appear on certificates and evidences of coverage. The bill also extends the required notice to policy forms issued by HMOs and health services plans. The bill requires the Commissioner of Health to conduct a study of various issues regarding the Commonwealth's role in overseeing the quality of care provided by managed care insurance plans. Lastly, the legislation requires the Department of Health to handle consumer complaints regarding quality of care issues forwarded to the Department by the Bureau of Insurance. This legislation emanated from a study of this issue published as 1997 Senate Document 7. (Appendix A, page 30)

Related Budgetary Action: A total of $220,000 ($170,000 GF and $50,000 NGF) and four positions was appropriated in FY 1998.

HB 2786 Provides that the Essential and Standard Health Benefits plans shall provide 365 days of inpatient hospital care, and expands the statutory authority of the Special Advisory Commission on Mandated Benefits to review the Essential and Standard plans and recommend changes to the Bureau of Insurance. This legislation emanated from a study of this issue published as 1997 House Document 27. (Appendix A, page 34)

House Joint Resolutions (HJR) and Senate Joint Resolutions (SJR)

SJR 297/ HJR 631 Establish a task force with the Joint Commission on Health Care to develop options to enhance the opportunity of Virginia's businesses to offer employees the option of participating in a "point-of-service" plan without increasing the employer's contribution to health benefits. These companion resolutions emanated from a study of this issue published as 1997 House Document 79. (Appendix A, pages 61 and 72)

Related Budgetary Action: A total of $100,000 GF was appropriated to support this study.

SJR 298 Directs the Joint Commission on Health Care to study various issues regarding Virginia's indigent and uninsured populations. (Appendix A, page 63)

SJR 316/ HJR 655 Establish a task force within the Joint Commission on Health Care to address outstanding aging and long-term care issues. (Appendix A, pages 65 and 74)

Related Budgetary Action: A total of $125,000 GF was appropriated to support this study.

SJR 317 Directs the Secretary of Health and Human Resources to review the boards, commissions, and councils within the Secretariat and recommend any appropriate revisions, consolidations or restructuring. This resolution emanated from a study of this issue published as 1997 Senate Document 8. (Appendix A, page 67)

SJR 343 Memorializes Congress to allow PACE projects to receive provider status for purposes of reimbursement from Medicare and Medicaid. This resolution emanated from a study of this issue published as 1997 House Document 28. (Appendix A, page 68)

HJR 551 Expresses the General Assembly's support for Virginia Health Information's strategic plan for developing and publishing useful health care cost and quality information. (Appendix A, page 69)

HJR 611 Directs the Bureau of Insurance to study whether certain provisions of Chapter 43 of Title 38.2 (the HMO Act) should apply to other managed care products. This resolution emanated from a study of this issue published as 1997 Senate Document 7. (Appendix A, page 71)

II. REVIEW OF THE IMPACT OF MANAGED CARE ON THE AVAILABILITY AND QUALITY OF ANCILLARY MEDICAL SERVICES

Virginia's "Freedom of Choice " Law Was Enacted in 1994

The 1994 Session of the General Assembly passed House Bill 840 which provided that health insurers and health maintenance organizations (HMOs) issuing policies or contracts requiring use of network providers could not prohibit an enrollee from receiving pharmacy or ancillary medical services from the provider of his/her choice so long as the provider accepted the insurer/HMO's reimbursement as payment in full. This legislation commonly is referred to as Virginia's "freedom of choice" law.

While the term "ancillary medical services" was not defined in the statute, the Bureau of Insurance, through its regulatory authority, ruled that carriers and HMOs should interpret the term very broadly to include durable medical equipment companies, home health agencies, medical laboratories, and other related medical service providers.

"Freedom of Choice" Provisions Relating to Ancillary Medical Services Were Repealed in 1995

The General Assembly amended the "freedom of choice" law in 1995 (House Bill 2304) by repealing the provisions which had applied to ancillary service providers. In addition, a third enactment clause was included in HB 2304 directing the Joint Commission on Health Care to conduct a three-year study of ancillary medical services insofar as the availability and quality of these services are affected by managed care. The legislation directed the Joint Commission to include its findings in its 1996, 1997, and 1998 reports to the Governor and the General Assembly. This section of the Joint Commission's 1996 Annual Report represents the initial phase of the three-year study.

There Are No Agreed Upon Methods Of Measuring The Impact Of Managed Care On The Availability And Quality Of Ancillary Medical Services

Determining whether managed care has affected the availability and quality of ancillary medical services is difficult at best. To date, there has been little, if any, research that has addressed this issue. One of the most perplexing issues in the entire health care arena is defining what "quality" care is. At present, there is no consensus or agreed upon definition of "quality health care." Without a definition of "quality" care, an accurate, objective, and valid measure of quality becomes virtually impossible.

Measuring the "availability" of health care services, such as ancillary medical services, poses fewer methodological problems than measuring quality. However, because there are no existing data, to do so would require a significant amount of primary data collection. It is clear that most managed care entities (i.e., HMOs, preferred provider organizations, and "point-of-service" plans, etc.) contract with fewer ancillary service providers to deliver services to their enrollees than traditional indemnity insurers. As a result, managed care plans typically reduce the number of providers from which enrollees can receive covered services. However, this does not necessarily mean that the services are less available to the enrollees. Thus, simply comparing the number of ancillary service providers available to enrollees prior to the 1995 repeal of the "freedom of choice" law with the number currently available does not address the question of whether the availability of services has been affected.

Due to the absence of any previous research, primary data collection or other quantitative measures, interviews were held with various ancillary service providers and representatives of the insurance/HMO industry to obtain information from different perspectives as to how the repeal of the "freedom of choice" law has affected the availability and quality of ancillary medical services for managed care enrollees.

Thus Far, There Is Little Concrete Evidence That The Availability Of Ancillary Medical Services Has Been Affected Adversely; However, A Number Of Providers Report That They Serve Fewer Managed Care Enrollees Today Than They Did When The "Freedom Of Choice" Law Originally Was Passed

From the perspective of the ancillary medical services provider community, the repeal of the "freedom of choice" law unquestionably has reduced the number of managed care enrollees that many of these

providers serve. Regarding the availability of services, there is little concrete evidence at this time that patients are not able to access necessary services. However, the repeal has resulted in some patients not being able to receive covered services from the provider of their choice.

One area that was mentioned as a possible access/availability problem is when there are changes in the ancillary service provider(s) contracting with the managed care plan and the former provider's equipment needs to be replaced with the new provider's equipment. Another similar situation is when the enrollee changes to a different managed care health plan and must receive his/her equipment or services from the new managed care plan's provider. According to some ancillary providers, there is a risk that these situations may result in patients experiencing a gap in services.

The HMO industry reports that it has not experienced any noticeable increase in the number of enrollee complaints regarding the availability of ancillary medical services. At the end of last year, the Department of Medical Assistance Services, which administers managed care programs (i.e., Options and Medallion II) for Virginia's Medicaid recipients, reported very few complaints regarding the availability of these services.

The Ability To Accurately Measure The Impact Of Managed Care On The Quality Of Ancillary Medical Services Is Very Limited

As previously noted, defining and measuring the quality of health care services, whether they be ancillary services, primary care services, surgical care, or other types of services, is a continuing problem for health care researchers, providers, insurers, and policymakers. An enormous investment of time and resources would be necessary to develop a valid methodology of defining and measuring "quality." In the absence of these resources, the ability to accurately measure the impact of managed care on the quality of ancillary medical services is very limited.

Many Ancillary Service Providers Believe The Quality Of Care Is Less Under Managed Care Plans

When asked what impact managed care is having on the quality of ancillary medical services, many providers argue that when patients are required to leave their current provider and switch to the managed care plan's provider, the continuity of care is disrupted and the quality of care is lowered. They also argue that patients' perception of quality is lowered when they cannot receive covered services from their provider of choice. Several providers indicated that some patients have reported not being

pleased with the quality of services they receive from their managed care plan's provider. However, without a more comprehensive analysis of this issue, the true impact on quality cannot be determined.

HMOs Report No Noticeable Increase In Enrollee Complaints And Argue That They Can Better Monitor The Quality Of Care By Contracting With A Limited Number Of Providers

Similar to the issue of the availability of services, HMOs indicate that they have not seen any noticeable increase in the number of enrollee complaints regarding the quality of ancillary medical services. The HMOs also note that ensuring the quality of their ancillary medical service providers is very important to them. Because some of these providers are entering the homes of the HMOs' enrollees, the HMOs want to ensure the quality of the services and the persons delivering the services. The HMOs argue that under a "freedom of choice" law they have a very limited ability to monitor the quality of a provider's services because they either do not know the provider or do not interact with the provider on a consistent basis. The HMOs contend that they are better able to control the quality of services when they contract with a limited number of providers whom they have reviewed and are satisfied that they will deliver quality services.

The Department Of Health Is Conducting A Study On The State's Role In Overseeing The Quality Of Care Provided Under Managed Care Plans

As required by HB 2785 of the 1997 Session of the General Assembly, the Department of Health (DOH) is conducting a study on what the state's role should be in overseeing the quality of health care services provided in managed care plans. As part of its study, DOH is meeting with providers (including ancillary medical providers), consumers, purchasers, and managed care plans to discuss various issues regarding the quality of managed care plan health services and what oversight by the state is needed. The issues of access and availability of services are included in the scope of the study. The findings and recommendations of the DOH study should provide insight into whether any state oversight of managed care plans' provision of ancillary medical services is needed.

Some Ancillary Medical Service Providers Have Expressed Concern Over The Manner In Which Some Patients Are Referred To Particular Ancillary Service Providers

While not a direct focus of this review, several ancillary service providers expressed concern over the growing number of patients who are referred or "steered"to a specific ancillary service provider. Those providers with concerns argue that such arrangements limit competition in the marketplace and, similar to the impact of managed care plans, steer patients away from their businesses.

Ancillary Service Providers Believe The "Freedom Of Choice" Law Should Be Reinstated; HMOs And The Insurance Industry Believe The Law Should Not Be Reinstated

Ancillary service providers believe that the "freedom of choice" provisions should be reinstated to assure the availability and quality of these services. They also believe patients should: (i) be able to participate in their discharge planning; (ii) be given information regarding all providers in a particular service area; and (iii) be able to receive services from the provider of their choice.

The HMO/insurance industry believes the law should not be reinstated and that there is no evidence to suggest that such a change is needed.

The Joint Commission will continue to monitor this issue and will include updates and further information in its 1997 and 1998 annual reports. Effective July 1, 1997, the Department of Health will be receiving and responding to consumer complaints regarding quality of care issues. This information will reviewed and included in subsequent Joint Commission reports on this topic.

The Joint Commission Is Studying Whether HMOs Should Be Mandated To Include "Point-of-Service" Plans In Their Benefit Offerings And Have The Choice Of Plans At The Employee Level

During 1997, pursuant to Senate Joint Resolution 297 and House Joint Resolution 631, the Joint Commission will be studying whether HMOs should be mandated to include "point-of-service" plans in their benefit offerings and have the choice of plans at the employee level. The study will also look at other ways to expand consumer choice of insurance plans. The issues to be examined in this study have a direct bearing on the concerns of ancillary service providers regarding the impact of managed care. Thus, the issues raised by ancillary service providers will continue to be analyzed through the course of this study.

III. HEALTH CARE ISSUES FACING VIRGINIA AND THE NATION

While many other health care issues are demanding the attention of the Commonwealth and the nation, three challenges are foremost:

- How to provide health care for the uninsured, and health protections for at-risk populations.
- How to prepare for the rapid demographic shift that is increasing the demand for long-term care.
- How to monitor and ensure quality in the health care marketplace.

This report provides an overview of Virginia's current efforts to answer these challenges. It also reviews the Commonwealth's response to Kassebaum-Kennedy federal health insurance reforms (The Health Insurance Portability and Accountability Act of 1996), and reflects the transformation of the health care market, both statewide and nationally.

CHANGES IN THE HEALTH CARE DELIVERY SYSTEM

The rapid pace of growth and change in the Virginia's health care delivery system is more the result of market pressures than state or federal reforms. Occupancy rates in hospitals, nationwide, have moved below 60 percent, motivating bed closures and administrative cuts. Physician income is dropping, in tandem with a switch to salaried positions, versus self-employment. And managed care plans are replacing a larger and larger share of traditional fee-for-service plans. Hospitals, physicians, insurers and others are responding to the changing marketplace by forming alliances and branching into areas beyond their traditional jurisdictions.

Managed Care

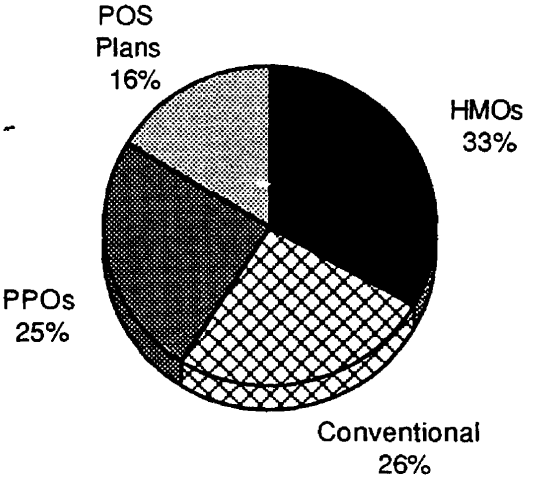
What was, in the late 1980s, a shift to the broad concept of managed care, has become, in the late 1990s, a move toward more integrated and refined

models, with defined pools of providers and access to care coordinated and managed by a primary care physician. Nationwide, nearly one in four individuals (22.4%) is covered by a Health Maintenance Organization (HMO), the most widely tracked form of managed care. Enrollment in other managed care plans, such as Preferred Provider Organizations (PPOs) and Point-of-Service plans (POS) is growing rapidly, as well. At the same time, the boundaries between the various forms of managed care are becoming less distinct. (See Figure 1)

Figure 1

Market Share of Employer-Sponsored Health Plans

1996



Source: Healthcare Trends Report, January, 1997

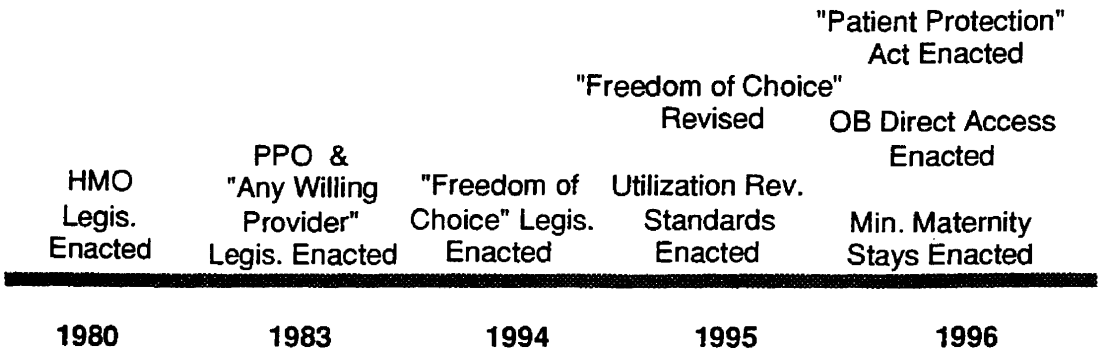
The number of Virginians enrolled in managed care plans has increased dramatically since 1990. Among them are 183,000 state employees who participate in the Key Advantage and HMO plans, and more than 330,000 Medicaid recipients. These numbers will continue to increase as the public and private sector gain from managed care's emphasis on prevention and cost containment.

While HMOs have been specifically regulated in Virginia, other forms of managed care, including PPOs and POS plans have not been subject to the same oversight. As such, the Bureau of Insurance now is investigating

whether certain provisions of the Code, which currently pertain only to HMOs, should be extended to other managed care products. This is the latest in a series of actions that Virginia has taken to both accommodate the evolution of the managed care industry and provide protection to Virginians enrolled in such plans. (See Figure 2)

Figure 2

History of Managed Care Legislation in Virginia



Source: Joint Commission on Health Care Staff Analysis

Toward An Integrated Delivery System

While today, the health care system in Virginia, and the nation, is comprised of independent "components" (hospitals, insurers, physicians, etc.), it is hoped that, eventually, these divisions between providers will be replaced by an integrated delivery system, which unifies the provision of care with its financing. This type of structure weaves together all levels of care to create a system with a single incentive – to keep people healthy. To be successful, an integrated delivery system must establish interdependence among all of the providers, eliminating cost shifting and creating fair and equitable distribution throughout the continuum of care.

Insurers, hospitals, physician groups and others have developed and are promoting their own models for integrated service delivery. While they differ in specifics, their goals, in terms of patient care, are the same. It will be important to work with these groups toward the creation of a truly

integrated delivery system – a structure that provides the incentives needed for all partners to work together. As part of this progression, it will be important for Virginia's licensure laws to be adapted to accommodate changes in the traditional boundaries separating provider groups.

HEALTH INSURANCE REFORM

Individuals and small groups historically have experienced the most difficulty obtaining affordable, comprehensive health insurance. For a number of years, Virginia has been taking action to address these inequities, and has passed a series of small group and individual insurance reforms. Now, with the passage of the Health Insurance Portability and Accountability Act of 1996 (Kassebaum-Kennedy), and the subsequent Virginia legislation (SB 1112, HB 2887), the state's existing individual reforms have been broadened and its small group reforms have been extended to include larger groups.

Individual Health Insurance Reform

Under Kassebaum-Kennedy, a newly defined group of "qualified" individuals must be offered policies on a guaranteed issue basis that include the following: guaranteed renewability (with standard exceptions); no pre-existing condition waiting periods; and credits for waiting periods served in previous coverage. Although far reaching, these reforms address only a defined, and very small, "eligible" population. To qualify, individuals must have had 18 months of coverage in a group health plan within the last 63 days; must not be eligible for other coverage (e.g., Medicare, Medicaid, or group insurance); and must have exhausted any COBRA eligibility.

Virginia already had provided individuals with "guaranteed renewability," limits on pre-existing condition waiting periods, and credits for waiting periods served in previous coverage. For certain eligible individuals, Kassebaum-Kennedy enhanced the state reforms, adding guaranteed issue of coverage and prohibiting pre-existing condition exclusions, including waiting periods. States were given some latitude in how they implemented the "guaranteed issue" provision for individuals. The approach Virginia chose provides individuals with the greatest choice of coverage options – similar to the approach taken in the small group market.

Group Health Insurance Reform

Kassebaum-Kennedy has extended most of the small group reforms already in place in Virginia to groups of all size. The legislation also extended Virginia's "guaranteed issue" reform to cover *all* plans, rather than solely "standard" and "essential," and widened the maximum group size to 50 from 25. Included in Kassebaum-Kennedy are other reforms that mirror those already enacted in the Commonwealth, including pre-existing condition waiting periods and guaranteed renewability.

Where necessary, Virginia has amended its insurance statues to comply with the new federal requirements. While not addressed in the Kassebaum-Kennedy reform, Virginia will continue to require carriers to rate primary small groups (2-25) on a modified community rating basis (for the essential and standards plans). This feature makes coverage more affordable for groups with medical risks without unduly penalizing others.

One of the highlights of Kassebaum-Kennedy is that the many of the group reforms now apply even to self-funded ERISA-exempted groups – a huge section of the health care marketplace that the Commonwealth had, heretofore, been unable to affect. (See Figure 3)

Changes Spur Creation Of Virginia Children's Medical Security Insurance Plan

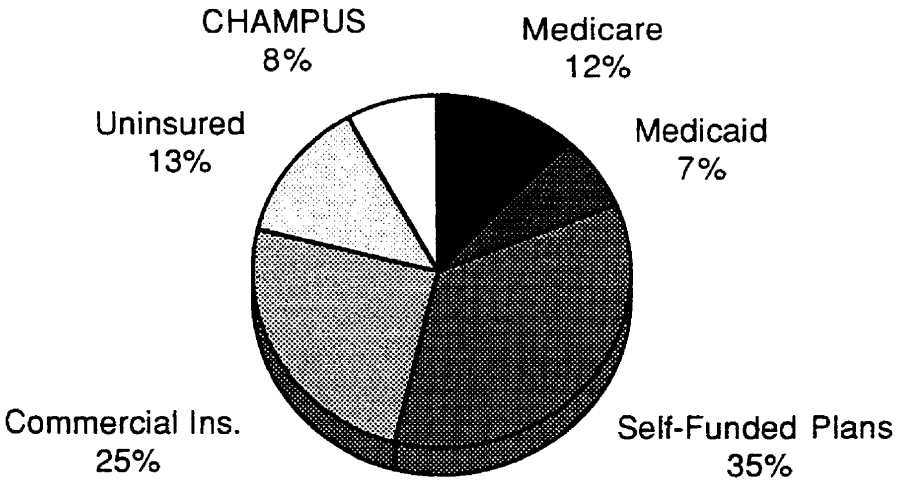
The "guaranteed issue" requirement for small groups included in Kassebaum-Kennedy essentially eliminated Virginia's primary reason for providing tax incentives to "open enrollment" carriers. By eliminating these tax advantages, the state will generate an estimated $7.5 million per year in additional general fund revenues. HB 2682 of 1997 captured the revenue generated through the change in the open enrollment status and channeled these resources into the creation of the Virginia Children's Medical Security Insurance Plan.

The Department of Medical Assistance Services (DMAS) has been directed to develop the proposal for implementing the Virginia Children's Medical Security Insurance Plan by December 1, 1997. The program will provide coverage to children (age 0-18) living in families with annual incomes at or below 200 percent of the federal poverty level.

Figure 3

Insurance Status Of Virginians

1996



Source: Joint Commission on Health Care Staff Analysis of 1996 Survey of Virginians' Health Status, Virginia Commonwealth University Survey & Research Laboratory

Other Implications of Kassebaum-Kennedy

A number of other changes were included in the Health Insurance Portability and Accountability Act of 1996, including a gradual increase in the deduction for health insurance premiums for self-employed individuals (rising from the current 30% to 80% by the year 2000), and tax exemptions for unreimbursed expenses for qualified long-term care services. Also, while HIPAA does not mandate that states take action on Medical Savings Accounts (MSAs), Virginia's Tax Department is coordinating an inter-agency task force to develop a MSA plan for consideration by the 1998 session.

CARING FOR THE UNINSURED AND MEDICALLY UNDERSERVED

While the Kassebaum-Kennedy legislation and subsequent Virginia reforms have done much to address the health insurance needs of individuals and small groups, the fact remains that more than 850,000 Virginians are uninsured. Many thousands of others have access to

insurance, but live in areas of the state that have a shortage of primary care providers.

The Joint Commission, in cooperation with the Board and Department of Health, the Board and Department of Medical Assistance Services, the Commonwealth's academic health centers, and various governmental, public and private entities, is involved in a comprehensive study of the provision of health care for the indigent and uninsured, as directed by SJR 298.

The Uninsured

The working poor and their families are, by far, the most likely Virginians to be uninsured, according to a 1996 survey by the Virginia Health Care Foundation. Most of the state's uninsured (57%) work full time, another 12 percent of the rest are employed part-time. Their average annual household income is less than $30,000.

Health insurance is available to many of the uninsured through employer-sponsored plans, but, for nearly half (47%), the cost of premiums is too high. Others work too few hours (15%) or are too newly employed to qualify for coverage (32%).

Due to their lack of health insurance, these adults and children are far less likely to receive ongoing primary care, and suffer from preventable, and costly, diseases and complications.

Changes in employee and employer shares of health insurance premiums impact coverage decisions. This forces many low income employees to eliminate coverage for themselves and/or their dependents. For others, insurance is unaffordable, due to pre-existing conditions.

Medicaid, which is administered by the Commonwealth and funded by the state and federal government, is the major program available for low-income persons who do not have insurance. It also finances care for several "special populations," including the mentally and physically disabled and the indigent elderly.

Between 1990 and 1995, the number of Virginia Medicaid recipients grew by 68 percent, with the expenditures during this period growing by 112 percent. Currently, 725,000 Virginians receive Medicaid-funded health care services.

Until recently, many Medicaid enrollees were using hospital emergency rooms as their primary point of access. Not only was this utilization inappropriate, given the non-emergent needs of the typical patient, it was extraordinarily expensive. In addition, it provided few opportunities for follow-up or preventive care.

Today, nearly three quarters of Medicaid recipients are participating in one of the state's three managed care programs. These programs, outlined below, are intended not only to reduce costs, but to provide true primary care: continuous, comprehensive and coordinated.

- Medallion I – By establishing a system through which Medicaid patients have a personal primary care physician who provides case management oversight as well as any needed care, the Department of Medical Assistance Services has tackled the issue of continuity of care. Participating physicians ensure that their Medicaid patients receive appropriate primary care in a fee-for-service environment.

- Options – Virginia Medicaid patients participating in Medallion I are offered a choice: either continue with the Medallion I plan or enroll in a participating area HMO.

- Medallion II – Nearly two years ago, Tidewater area Medicaid enrollees were transferred to Medallion II, an HMO-only plan. Today, approximately 90,000 Medicaid recipients in the Tidewater area are enrolled in Medallion II, which emphasizes preventive care and case management.

Future efforts will include reforming the state's managed care approaches to better meet the needs of *all* Medicaid enrollees, both the uninsured and those in special populations.

The Underserved

Even those with insurance coverage are not guaranteed access to needed services. Some cannot find providers willing to accept low income patients. Others live in medically underserved areas, both urban and rural, in which there is a shortage of primary care professionals.

Virginia has placed substantial emphasis on increasing the number of primary care providers in underserved areas. Among the current initiatives are two important programs sponsored, in part, by the Robert Wood Johnson Foundation. Working with the Commonwealth's three

medical schools, the Generalist Initiative focuses on increasing the number of medical students who choose to practice primary care. The Practice Sights Initiative is directed toward increasing recruitment and retention of primary care providers in underserved areas across Virginia.

Among the tools being investigated to alleviate health professional shortages is telemedicine -- the use of technology to help deliver medical care or medical education. Several telemedicine initiatives already are underway, and others are under review. The Virginia Health Care Foundation, initiated by the Joint Commission, funds and administers a number of projects, including some telemedicine initiatives, that are designed to increase the number of primary care providers in medically underserved areas. In addition, the state sponsors a variety of scholarship and loan repayment programs to provide financial assistance and incentives to those choosing to practice in underserved areas.

Both together and individually, these programs are generating important benefits for the state, in terms of increasing the pool of primary care practitioners for underserved communities. Despite their contributions, however, they cannot overcome the issue of financial access.

Unique Health Care Challenges Facing African-Americans

Although many of the uninsured, as well as many residents in medically underserved communities, are African-American, the particular needs of this population are cause for more in-depth study. The rates of many diseases, conditions, and health risk factors (such as diabetes, hypertension, teenage pregnancy and crime) are significantly higher in the African-American community.

As a result of Senate Joint Resolution 355, the Joint Commission is working with the Office of Minority Health of the State Department of Health to study the health status and conditions of African-Americans in the Commonwealth, and to propose actions to remedy identified problems.

LONG-TERM CARE

Long-term care is one of the most important health care reform issues affecting the Commonwealth for a number of reasons:

- The elderly population is projected to grow significantly faster in Virginia than in the nation as a whole. In 1990, there were about 677,000 Virginians age 65 and older. In 20 years, this number will increase by almost 40 percent, and the population of Virginians age 85 and older will more than double by 2010.

- The "baby boom" generation is heading toward retirement age, leaving a smaller workforce to pay for the care of an increasing population of retirees.

- The rise in single parent households, the decrease in the number of "at home" parents, and geographic separation between elders and their children mean that families are less able to provide long-term care to infirmed parents on a full-time basis.

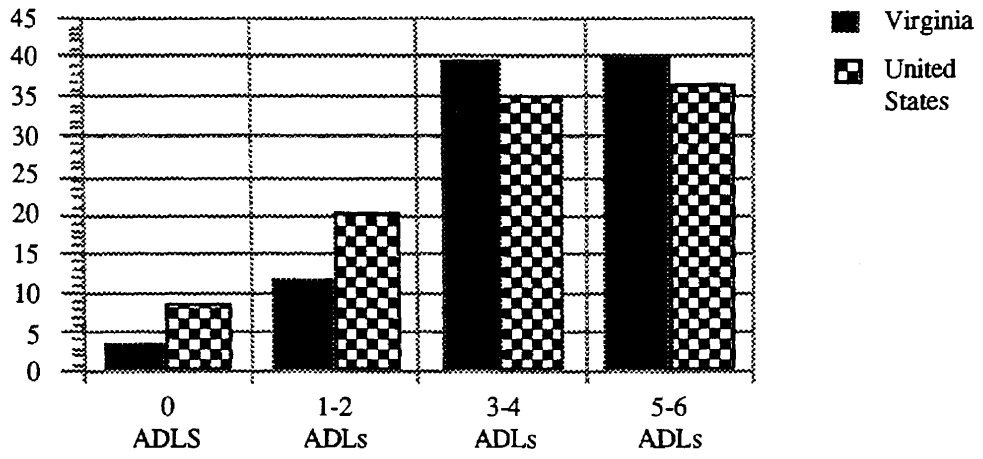
Add in health care cost inflation, and it is clear that it will be extremely difficult to maintain the current system of financing and delivering long-term care.

Containing Long-Term Care Costs

To deal with the state's increasing financial burden for nursing home care, Virginia has taken a variety of actions to limit the growth of expenditures. From 1988 through 1996, a moratorium was placed on the number of nursing home beds. Last year, this "cap" was amended to allow controlled growth in areas demonstrated to have a need for additional beds. The state also has limited the number of individuals who qualify for state-supported nursing home care by tightening eligibility requirements. All individuals must go through stringent pre-admission screening to determine whether they are functionally impaired to such a degree that they require institutional (i.e., nursing home) care. As a result, Virginia's nursing home residents are more functionally impaired than the national average, an indication that care is being provided to those most clearly in need. (See Figure 4)

Figure 4

Percent of Nursing Home Residents with ADL Limitations, 1989



A Joint Commission task force has been created to address outstanding long-term care and aging issues, such as consolidation of the acute and long-term care delivery system (SJR 316/HJR 655). Among the aspects of long-term care being studied by the task force are these:

- The Role of the Family: Where should the line be set between the family's responsibility and the state's. Instead of supplanting the family, the state needs to devise a system that provides support in a way that does not diminish the family's role. It also must reform long-term care financing to create a more equitable balance of cost sharing between families, insurers and public programs.

- Long-Term Care Insurance: It is crucial to re-examine Virginia's role in supporting long-term care insurance. Unless and until these policies are made practical, the state will increasingly be relied upon as a primary source of funding for long-term care.

- Setting-Based Reimbursement: Currently, long-term care provided in a nursing home setting is reimbursed at a significantly higher rate than home and community based care. While some of this disparity is

attributable to "inpatient" versus "outpatient" costs, there are convincing arguments in favor of narrowing the gap in reimbursement rates.

- Licensure: In addressing long-term care issues, it will be important for the state to maintain a balance between the overlapping issues of licensure, reimbursement, and quality across the entire continuum of care.

- Consolidation: Although past efforts directed toward consolidating long-term care related functions or even licensure into one state entity have not been successful, the potential advantages of such concepts are likely to be reexamined.

- Acute vs. Long-Term Care: Existing barriers between the long-term care and acute care systems interfere with the delivery of comprehensive coordinated care. Particularly problematic are the financial disincentives that motivate shifting of patients between hospitals and nursing homes.

The Joint Commission Task Force on Long-Term Care will be conducting briefings on these and other related long-term care issues in August, September, and October 1997.

MEASURING AND MONITORING QUALITY

The Joint Commission has been involved in charting a course for the Commonwealth in both quality and cost assessment, two important aspects of health care reform. Over the past several years, it has shepherded the state's move away from charge-based analysis toward patient-based analysis.

In the 1970s, the Virginia Health Services Cost Review Council was established to analyze health care charges in hospitals and nursing homes. As the market changed over the next two decades, it became apparent that the demand for data solely on the *cost* of care at the institutional level had been overtaken by a greater need to have an entity in place to monitor more patient focused data. As part of this shift, in 1993, Virginia Health Information (VHI) was awarded a contract to collect, analyze and disseminate patient-level health care data. Then, in 1996, the state moved to eliminate the Cost Review Council and transfer

additional responsibilities to VHI. This transition has resulted in a number of meaningful changes:

- Health plans and physicians are now in the process of being incorporated into the data collection and analysis process, in addition to the hospital and nursing home information formerly collected by the Cost Review Council.

- Rather than a state agency, VHI is a nonprofit public/private partnership which includes representatives from the business, consumer, hospital, nursing home, insurer and physician communities, as well as the state.

- The emphasis now is on information on health care quality that is accessible and of value to consumers, as well as being useful to the state and other health care purchasers.

Late in 1996, VHI presented its Strategic Plan to the Board of Health, Governor Allen, and the General Assembly. The plan, which extends through June 30, 1999, details VHI's proposals for developing information to assist consumers and purchasers in buying health care services or choosing health care providers. The General Assembly, through adoption of HJR 551, expressed its support of the plan. An update on VHI efforts toward these specific quality and data projects will be presented to the Joint Commission on October 1, 1997.

Both as a provider, through the state's two teaching hospitals, and as a financier, through the managed care programs now in place for Virginia employees and some Medicaid enrollees, the Commonwealth is a partner in the state's efforts to promote quality care. Beyond that, the most appropriate role for the state may be in continuing to foster quality improvements at the micro level, rather than promoting reform at the macro level.

Micro reform has proven particularly effective in the health care quality arena. Hospitals, for example, are expending tremendous effort to improve quality within their institutions. Through these individual efforts, the overall quality of health care is being improved for Virginians without relying on statewide reforms that could be extremely difficult to apply to such a geographically and demographically diverse area.

One ongoing challenge is that "quality" is highly subjective and often very difficult to quantify. While there are ways to measure *some* aspects of

APPENDIX A:

1997 Legislation

Joint Commission on Health Care
1997 Legislation
(As Approved)

Joint Commission on Health Care
1997 Legislation
(As Approved)

CHAPTER 321

An Act to amend and reenact § 32.1-111.3 of the Code of Virginia, relating to the statewide emergency medical care system.

[S 1034]

Approved March 13, 1997

Be it enacted by the General Assembly of Virginia:

1. That §32.1-111.3 of the Code of Virginia is amended and reenacted as follows:

§32.1-111.3. Statewide emergency medical care system.

A. The Board of Health shall develop a comprehensive, coordinated, emergency medical care system in the Commonwealth and prepare a Statewide Emergency Medical Services Plan, which shall incorporate, but not be limited to, the plans prepared by the regional emergency medical services councils. The Board shall review the Plan triennially and make such revisions as may be necessary. The objectives of such Plan and the system shall include, but not be limited to, the following:

1. Establish a comprehensive statewide emergency medical care system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

2. Reduce the time period between the identification of an acutely ill or injured patient and the definitive treatment;

3. Increase the accessibility of high quality emergency medical services to all citizens of Virginia;

4. Promote continuing improvement in system components including ground, water and air transportation, communications, hospital emergency departments and other emergency medical care facilities, consumer health information and education, and health manpower and manpower training;

5. Improve the quality of emergency medical care delivered on site, in transit, in hospital emergency departments and within the hospital environment;

6. Work with medical societies, hospitals, and other public and private agencies in developing approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be served more appropriately and economically;

7. Conduct, promote, and encourage programs of education and training designed to upgrade the knowledge and skills of health manpower involved in emergency medical services;

8. Consult with and review, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs;

9. Establish a statewide air medical evacuation system which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate state agencies;

10. Establish and maintain a process for designation of appropriate hospitals as trauma centers and specialty care centers based on an applicable national evaluation system;

11. Establish a comprehensive emergency medical services patient care data collection and evaluation system pursuant to Article 3.1 (§32.1-116.1 et seq.) of this chapter; and

12. Collect data and information and prepare reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§2.1-340 et seq.).

B. *The Board of Health shall also promulgate regulations to establish a statewide prehospital and interhospital trauma triage plan which (i) sets standards and criteria for triage and for trauma center designations and (ii) is designed to provide quality improvement monitoring and to ensure that trauma patients receive rapid access to appropriate, organized trauma care. The first set of such regulations shall be effective in 280 days or less from enactment of this provision.*

C. Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of this section, an appropriate amount not to exceed the actual costs of operation may be charged by the agency having administrative control

of such aircraft, vehicle or other form of conveyance.

CHAPTER 475

An Act to amend and reenact § 38.2-226.1 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 10 of Title 32.1 a section numbered 32.1-330.3, relating to health insurance; exemption from insurance regulation for certain long-term care prepaid health plans.

[S 1102]
Approved March 18, 1997

Be it enacted by the General Assembly of Virginia:

1. That §38.2-226.1 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 10 of Title 32.1 a section numbered 32.1-330.3 as follows:

§32.1-330.3. Operation of a pre-PACE plan; oversight by Department of Medical Assistance Services.

A. 1. Operation of a pre-PACE plan that participates in the medical assistance services program must be in accordance with a prepaid health plan contract with the Department of Medical Assistance Services.

2. As used in this section, "pre-PACE plans" mean long-term care prepaid health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

B. All contracts and subcontracts shall contain an agreement to hold harmless the Department of Medical Assistance Services and pre-PACE participants in the event that a pre-PACE provider cannot or will not pay for services performed by the subcontractor pursuant to the contract or subcontract.

C. During the pre-PACE period, the program shall have a fiscally sound operation as demonstrated by total assets being :er than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become and a plan for handling insolvency approved by the Department of Medical Assistance Services.

D. The pre-PACE plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event of insolvency:

1. One month's total capitation revenue to cover expenses the month prior to insolvency; and

2. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

Appropriate arrangements to cover expenses must include one or more of the following: reasonable and sufficient net worth, insolvency insurance, letters of credit or parental guarantees.

E. Pre-PACE plans which contract with private pay participants shall, at all times, hold in a segregated escrow account an amount at least equal to two months' capitation payment for each private pay participant of the pre-PACE site. Such amounts shall be in addition to any amounts or other arrangements required under subsection D and shall be used to assist the private pay participants in obtaining substitute services in the case of insolvency or other failure of the pre-PACE site.

1. Enrollment at any one pre-PACE site of private pay participants shall be limited to a maximum of five percent.

2. For the purposes of this section, "private pay participants" means those persons who do not participate in programs authorized pursuant to Title XVIII of the United States Social Security Act, or Title XIX of the United States Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1.

F. Full disclosure shall be made to all private pay participants, and to those individuals in the process of enrolling in the pre-PACE site, that the pre-PACE program is not insurance and should not be considered a substitute for insurance. In addition, disclosure shall include a statement that services are not guaranteed beyond a thirty-day period.

The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license irements, regulations and ongoing oversight. The Advisory Group shall include representatives from each of the owing organizations: Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of Insurance, Board of Medicine, Board of Pharmacy, Department for the Aging and a pre-PACE provider.

§38.2-226.1. Provisions of title not applicable to certain long-term care prepaid health plans.

A. This title shall not apply to pre-PACE, long-term care prepaid health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

B. The pre-PACE, long-term care prepaid health plans identified in subsection A may include coverage for individuals ~~who have made application for medical assistance services pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1. Such coverage shall not extend beyond ninety days after the date of such application unless (i) such individuals' applications are approved or (ii) any disapproval thereof is pending appeal conforming to the procedures established for the same by the Department of Medical Assistance Services, and then only for the duration of such appeal~~ *eligible for medical assistance services and those whose coverage is paid from private sources including commercial coverage.*

CHAPTER 807

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

[S 1112]
Approved April 2, 1997

Be it enacted by the General Assembly of Virginia:

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

Article 4.1. Individual Health Insurance Coverage.

§38.2-3430.1. Application of article.

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

38.2-3430.2. Definitions.

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

B. For purposes of this article:

"Eligible individual" means an individual:

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

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

3. With respect to whom the most recent coverage within the coverage period described in subdivision 1 was not terminated based on a factor described in 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.

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

A. Guaranteed availability.

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

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

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

§38.2-3430.4. Special rules for network plans.

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

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

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

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

§38.2-3430.5. Application of financial capacity limits.

A. A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the health insurance issuer has demonstrated to the satisfaction of the Commission that:

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

2. It is applying this section uniformly to all individuals in the individual market in the Commonwealth consistent with the laws of this Commonwealth and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

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

§38.2-3430.6. Market requirements.

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

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

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

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

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

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

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

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

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

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

C. Requirements for uniform termination of coverage.

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

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

b. The health insurance issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the health insurance issuer for individuals in such market; and

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

2. Discontinuance of all coverage.

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

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

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

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

§38.2-3430.8. Certification of coverage.

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

§38.2-3430.9. Regulations establishing standards.

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

B. The Commission may revise or amend such regulations and may increase the scope of the regulations to the extent

necessary to maintain federal approval of the Commonwealth's program for regulation of health insurance issuers pursuant to the requirements established by the United States Department of Health and Human Services.

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

§38.2-3430.10. Effective date.

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

Article 5. ~~Small Employer Market Provisions.~~ *Group Market Reforms and Individual Coverage Offered to Employees of Small Employers.*

§38.2-3431. Application of article; definitions.

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

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

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

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

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

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

B. For the purposes of this article:

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

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

1. Such period shall begin on the enrollment date.

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

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

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

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

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

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

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

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

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

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

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

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

"COBRA continuation provision" means any of the following:

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

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

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

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

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

1. A group health plan;

2. Health insurance coverage;

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

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

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

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

7. A state health benefits risk pool;

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

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

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

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

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

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of thirty or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee.

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

1. In accordance with the terms of such plan;

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

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

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

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

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

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

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

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

1. Benefits not subject to requirements of this article:

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

b. Coverage issued as a supplement to liability insurance;

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

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

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

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

a. Limited scope dental or vision benefits;

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

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

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

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

b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

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

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

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

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

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

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

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

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

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

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

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

"Late enrollee" means ~~an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the health benefit plan.~~ *. with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:*

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

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

"Medical care" means amounts paid for:

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

2. Amounts paid for transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Amounts paid for insurance covering medical care referred to in subdivisions 1 and 2.

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

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

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

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

"Plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 974 (29 U.S.C. § 1002 (16)(B)).

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

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

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

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

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

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

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

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

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

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

"Waiting period" means with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

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

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

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

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

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

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

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

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

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

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

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

3. ~~Within 180 days after the Commission's approval of essential and standard health benefit plans, every small employer carrier~~ *Every health insurance issuer offering group health insurance coverage* shall, as a condition of transacting business in Virginia with ~~primary~~ small employers, offer and make available to ~~primary~~ small employers an essential and a standard health benefit plan.

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

~~5.~~ *4.* All essential and standard benefit plans issued to ~~primary~~ small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium. A ~~small employer carrier~~ *health insurance issuer* shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by §38.2-316. Each rider, separate policy or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a ~~small employer carrier~~ *health*

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

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

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

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

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

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

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

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

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

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

d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than ~~ninety-nine~~ *fifty* eligible employees until the later of 180 days after closure to new applications or the date on which the ~~carrier~~ *health maintenance organization* notifies the Commission that it has regained capacity to deliver services to small employers. In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision ~~7~~ *6* of this subsection apply.

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

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

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

. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by

small employers to information concerning this article;

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

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

§38.2-3432.1. Renewability.

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

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

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

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

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

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

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

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

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

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

10. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the group market in this Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only in accordance with the laws of this Commonwealth and if: (i) the health insurance issuer provides notice to the Commission and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage and (ii) all health insurance issued or delivered for issuance in this Commonwealth in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed;

11. In the case of a discontinuation under subdivision 9 of this subsection in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market and this Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed;

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

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

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

B. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

§38.2-3432.2. Availability.

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

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

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

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

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

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

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

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

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

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

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

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

F. Nothing in this article shall be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules in connection with a health benefit plan offered in the small group market. As used in this article, the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of eligible individuals and the term "group participation rule" means a requirement relating to the minimum number of eligible employees that must be enrolled in relation to a specified percentage or number of eligible employees. Any employer contribution rule or group participation rule shall be applied uniformly among small employers without reference to the size of the small employer group, health status of the small employer group, or other factors.

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

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

1. Such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

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

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

B. Exceptions:

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

2. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

3. A health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition; and

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

C. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan, if, after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage.

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

E. Methods of crediting coverage:

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

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

3. In the case of an election with respect to a group plan under subdivision 2 of this subsection (whether or not health insurance coverage is provided in connection with such plan), the plan shall: (i) prominently state in any disclosure

statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election and (ii) include in such statements a description of the effect of this election; and

4. In the case of an election under subdivision 2 of this subsection with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall: (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election and (ii) include in such statements a description of the effect of such election.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

K. If: (i) a health insurance issuer makes coverage available with respect to a dependent of an individual; (ii) the individual is

a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and (iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer shall provide for a dependent special enrollment period described in subdivision J 2 during which the person (or, if not otherwise enrolled, the individual) may also be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

L. A dependent special enrollment period under this subsection shall be a period of not less than thirty days and shall begin on the later of:

1. The date dependent coverage is made available; or

2. The date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subdivision J 3.

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

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

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

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

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

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

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

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

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

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

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

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

3. Provisions affecting any preexisting conditions provision.

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

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

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

§38.2-3434. Disclosure of information.

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

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

§38.2-3435. Exclusions.

The provisions of this article shall not apply to:

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

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

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

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

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

§38.2-3436. Eligibility to enroll.

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

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

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

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

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

Nothing in subsection C shall be construed:

o restrict the amount that an employee may be charged for coverage under a group health plan or group health insurance overage; or

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

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

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

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

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

§38.2-4214. Application of certain provisions of law.

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

§38.2-4216.1. Open enrollment.

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

B. As used in this section, the term:

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

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

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

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

of such advertising shall be generally approved by the Commission.

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

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

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

§38.2-4217. Reports.

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

In addition to the annual statement required by §38.2-1300, the Commission shall require each nonstock corporation to file annually, on or before June 1, an annual statement, signed by two of its principal officers subject to §38.2-1304, showing:

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

a. Individual, open enrollment;

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

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

~~d. Associations;~~

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

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

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

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

§38.2-4229.1. Conversion to domestic mutual insurer.

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

Any nonstock corporation eligible to convert to a domestic mutual insurer under subsection A of this section may effect a conversion by amending its articles of incorporation to delete any reference to this chapter and to comply with the provisions of §38.2-1002 relating to the articles of incorporation of a domestic mutual insurer. Upon the issuance of a

certificate of amendment by the Commission, the conversion shall be effective, such nonstock corporation shall become subject to all of the provisions of this title relating to domestic mutual insurers, and, except as provided in subsection D of this section, such nonstock corporation shall no longer be subject to the provisions of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commission.

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

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

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

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

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

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

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

§38.2-4322. Affiliation period.

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

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

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

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

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

D. Defined terms as set forth in §38.2-3431 which are used in this chapter shall have the same meaning here that they have in Chapter 34.

§38.2-4323. Alternative methods.

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

§58.1-2501. Levy of license tax.

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

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

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

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

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

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

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

3. That the Bureau of Insurance within the State Corporation Commission, in cooperation with the Joint Commission on Health Care, monitor the impact of the provisions of this act on the Commonwealth's health insurance marketplace. In monitoring the impact of this act, the State Corporation Commission shall: (i) review the federal regulations that will be promulgated to implement P.L. 104-191 (The Health Insurance Portability and Accountability Act of 1996), and determine whether any changes to this act are required by federal regulations adopted pursuant to P.L. 104-191; (ii) monitor the impact of the guaranteed issue requirements in the individual market and evaluate any specific concerns regarding such requirements identified and documented to the satisfaction of the State Corporation Commission by health insurance issuers; and (iii) recommend to the Governor and the 1998 Session of the General Assembly any revisions, corrections or improvements to the provisions of this act that would require the enactment of additional legislation.

CHAPTER 462

An Act to amend the Code of Virginia by adding in Article 1.1 of Chapter 4 of Title 32.1 a section numbered 32.1-102.12, relating to certificates of public need.

[H 2477]
Approved March 16, 1997

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1.1 of Chapter 4 of Title 32.1 a section numbered 32.1-102.12 as follows:

§32.1-102.12. Report required.

The Commissioner shall annually report to the Governor and the General Assembly on the status of Virginia's certificate of public need program. The report shall be issued by October 1 of each year and shall include, but need not be limited to:

1. A summary of the Commissioner's actions during the previous fiscal year pursuant to this article;

2. A five-year schedule for analysis of all project categories which provides for analysis of at least three project categories per year;

3. An analysis of the appropriateness of continuing the certificate of public need program for at least three project categories in accordance with the five-year schedule for analysis of all project categories;

4. An analysis of health care market reform in the Commonwealth and the extent, if any, to which such reform obviates the need for the certificate of public need program;

5. An analysis of the accessibility by the indigent to care provided by the medical care facilities regulated pursuant to this article and the relevance of this article to such access; and

An analysis of the relevance of this article to the quality of care provided by medical care facilities regulated pursuant to this article.

CHAPTER 414

An Act to amend and reenact § 38.2-226.1 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 10 of Title 32.1 a section numbered 32.1-330.3, relating to health insurance; exemption from insurance regulation for certain long-term care prepaid health plans.

[H 2784]
Approved March 15, 1997

Be it enacted by the General Assembly of Virginia:

1. That §38.2-226.1 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 10 of Title 32.1 a section numbered 32.1-330.3 as follows:

§32.1-330.3. Operation of a pre-PACE plan; oversight by Department of Medical Assistance Services.

A. 1. Operation of a pre-PACE plan that participates in the medical assistance services program must be in accordance with a prepaid health plan contract with the Department of Medical Assistance Services.

2. As used in this section, "pre-PACE plans" mean long-term care prepaid health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

B. All contracts and subcontracts shall contain an agreement to hold harmless the Department of Medical Assistance Services and pre-PACE participants in the event that a pre-PACE provider cannot or will not pay for services performed by the subcontractor pursuant to the contract or subcontract.

C. During the pre-PACE period, the program shall have a fiscally sound operation as demonstrated by total assets being greater than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due, and a plan for handling insolvency approved by the Department of Medical Assistance Services.

D. The pre-PACE plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event of insolvency:

1. One month's total capitation revenue to cover expenses the month prior to insolvency; and

2. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

Appropriate arrangements to cover expenses must include one or more of the following: reasonable and sufficient net worth, insolvency insurance, letters of credit or parental guarantees.

E. Pre-PACE plans which contract with private pay participants shall, at all times, hold in a segregated escrow account an amount at least equal to two months' capitation payment for each private pay participant of the pre-PACE site. Such amounts shall be in addition to any amounts or other arrangements required under subsection D and shall be used to assist the private pay participants in obtaining substitute services in the case of insolvency or other failure of the pre-PACE site.

1. Enrollment at any one pre-PACE site of private pay participants shall be limited to a maximum of five percent.

2. For the purposes of this section, "private pay participants" means those persons who do not participate in programs authorized pursuant to Title XVIII of the United States Social Security Act, or Title XIX of the United States Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1.

F. Full disclosure shall be made to all private pay participants, and to those individuals in the process of enrolling in the pre-PACE site; that the pre-PACE program is not insurance and should not be considered a substitute for insurance. In addition, disclosure shall include a statement that services are not guaranteed beyond a thirty-day period.

G. The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license requirements, regulations and ongoing oversight. The Advisory Group shall include representatives from each of the following organizations: Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of Insurance, Board of Medicine, Board of Pharmacy, Department for the Aging and a pre-PACE provider.

§38.2-226.1. Provisions of title not applicable to certain long-term care prepaid health plans.

A. This title shall not apply to pre-PACE, long-term care prepaid health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

B. The pre-PACE. long-term care prepaid health plans identified in subsection A may include coverage for individuals ~~who have made application for medical assistance services pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1. Such coverage shall not extend beyond ninety days after the date of such application unless (i) such individuals' applications are approved or (ii) any disapproval thereof is pending appeal conforming to the procedures established for the same by the Department of Medical Assistance Services, and then only for the duration of such appeal~~ *eligible for medical assistance services and those whose coverage is paid from private sources including commercial coverage.*

CHAPTER 688

An Act to amend and reenact §§ 38.2-305, 38.2-4214, 38.2-4308, 38.2-4315 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 4 of Title 32.1 an article numbered 7, consisting of a section numbered 32.1-122.10:01, relating to accident and sickness insurance; health maintenance organizations; contents of policies; State Health Commissioner review.

[H 2785]
Approved March 21, 1997

Be it enacted by the General Assembly of Virginia:

1. That §§38.2-305, 38.2-4214, 38.2-4308, 38.2-4315 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 4 of Title 32.1 an article numbered 7, consisting of a section numbered 32.1-122.10:01, as follows:

Article 7. Review of Health Services Quality.

§32.1-122.10:01. Review of health maintenance organizations.

A. The State Health Commissioner (the "Commissioner") shall examine the quality of health care services of any health maintenance organization ("HMO") licensed in Virginia pursuant to §§38.2-4301 and 38.2-4302 and the providers with whom the organization has contracts, agreements, or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth. The Commissioner shall consult with HMOs and providers in carrying out his duties under this section.

B. For the purposes of examinations, the Commissioner may review records, take affidavits, and interview the officers and agents of the HMO and the principals of the providers concerning their business.

C. The expenses of examinations by or for the Commissioner under this section shall be assessed against the organization being examined and remitted to the Commissioner.

D. In making his examination, the Commissioner may consider the report of an examination of a foreign HMO certified by the insurance supervisory official, a similar regulatory agency, an independent recognized accrediting organization, or the state health commissioner of another state.

E. The Commissioner also shall: (i) consult with HMOs in the establishment of their complaint systems as provided in § 38.2-4308; (ii) review and analyze HMOs' complaint reports which are required in subsection B of § 38.2-4308; and (iii) assist the State Corporation Commission in examining such complaint systems, as provided in subsection C of § 38.2-4308.

F. The Commissioner shall coordinate the activities undertaken pursuant to this section with the State Corporation Commission to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

§38.2-305. Contents of policies.

A. Each insurance policy or contract shall specify:

1. The names of the parties to the contract;

2. The subject of the insurance;

3. The risks insured against;

4. The time the insurance takes effect and, except in the case of group insurance, title insurance, and insurance written under perpetual policies, the period during which the insurance is to continue;

5. A statement of the premium, except in the case of group insurance and title insurance; and

6. The conditions pertaining to the insurance.

B. Each *new or renewal* insurance policy ~~or~~, contract, *certificate or evidence of coverage issued to a policyholder, covered person or enrollee* shall be accompanied by a notice stating substantially:

"IMPORTANT INFORMATION ~~TO POLICYHOLDERS~~ *REGARDING YOUR INSURANCE"*

"In the event you need to contact someone about this ~~policy~~ *insurance* for any reason please contact your agent. If *no agent was involved in the sale of this insurance, or if* you have additional questions you may contact the insurance company issuing this ~~policy~~ *insurance* at the following address and telephone number [Insert the appropriate address and telephone number, toll free number if available, for the company's home or regional office].

Health maintenance organizations shall add the following: We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia *State Corporation Commission's* Bureau of Insurance at: [Insert the appropriate address, toll free phone number, and phone number for out-of-state calls for the Bureau of Insurance.]

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available."

C. If, under the contract, the exact amount of premiums is determinable only at the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid shall be furnished to any policy-examining bureau having jurisdiction or to the insured upon request.

D. This section shall not apply to surety insurance contracts.

§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, *38.2-305*, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§38.2-1300 et seq.) and 2 (§38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§38.2-4308. Complaint system.

A. Each health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints. The complaint system shall be established after consultation with the State Health Commissioner and approval by the Commission.

B. Each health maintenance organization shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission, after consultation with the State Health Commissioner. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) a compilation of causes underlying the complaints filed, and (iv) the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the health maintenance organization and any of its health care providers. A record of the complaints shall be maintained for the period set forth in §38.2-511.

C. The Commission ~~or~~, *in cooperation with* the State Health Commissioner ~~may~~, *shall* examine the complaint system. *However, at its discretion, the Commission may accept the report of examination conducted by the State Health Commissioner instead of making its own examination.*

§38.2-4315. Examinations.

A. The Commission shall examine the affairs of each health maintenance organization as provided for in §38.2-1317 at least once every five years. The Commission may examine the affairs of providers with whom any health maintenance organization has contracts, agreements, or other arrangements according to its health care plan as often as it considers necessary for the protection of the interests of the people of this Commonwealth.

~~B. The State Health Commissioner may examine the quality of health care services of any health maintenance organization or providers with whom the organization has contracts, agreements, or other arrangements according to its health care plan as~~

~~often as considered necessary for the protection of the interests of the people of this Commonwealth.~~

~~C. For the purpose of examinations, the State Health Commissioner may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.~~

~~D. The expenses of examinations by or for the State Health Commissioner under this section shall be assessed against the organization being examined and remitted to the State Health Commissioner.~~

~~E.~~ *B.* Instead of making its own examination, the Commission ~~or State Health Commissioner~~ may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

C. The Commission shall coordinate such examinations with the State Health Commissioner to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

§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, *38.2-305*, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 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 the State Health Commissioner, in cooperation with the State Corporation Commission Bureau of Insurance, the Department of Health Professions, and other state agencies as appropriate, be requested to study the quality of health care services provided by health maintenance organizations.

A. The study should (i) examine quality of care mechanisms currently in place for health maintenance organizations (HMOs) and providers with whom they contract, including, but not limited to, state and federal statutes and regulations and review by private accrediting bodies, such as the National Committee for Quality Assurance; (ii) assess the sufficiency of these mechanisms for ensuring quality and providing health care consumers with a means of having their inquiries and complaints addressed; (iii) determine the extent to which such quality of care mechanisms currently exist for forms of managed care other than HMOs (described above) and whether any or all of such mechanisms should be expanded to entities other than HMOs; (iv) examine how the Department of Health and the Bureau of Insurance can coordinate their regulatory roles for ensuring quality of health care services in a manner which minimizes overlapping of authority and duplication of resources; and (v) identify the appropriate role of the Department of Health and any other appropriate state agencies in monitoring quality of care provided through HMOs, other managed care plans, and the providers with whom they contract.

B. The study also should consider whether changes in existing law or regulations are warranted with respect to: (i) the system for investigating and resolving complaints, including whether such system should include complaints by providers and other interested parties on matters which are not purely contractual in nature; (ii) addressing complaints regarding alleged violations of applicable laws or regulations and the manner in which such laws and regulations should be enforced in the Commonwealth; and (iii) whether there is a need in the Commonwealth for a mechanism to be created for the purpose of adjudicating controversies and resolving complaints in connection with alleged

violations of applicable law or regulation.

C. The State Health Commissioner also is requested to submit a report by October 1, 1997, to the Governor, the Joint Commission on Health Care and the General Assembly which, in addition to the matters to be reported on as set forth above, (i) recommends the appropriate role of the Commonwealth in monitoring and improving the quality of care in managed care plans which either require or create incentives for covered persons to use health care providers managed, owned, under contract with or employed by the health carrier; (ii) recommends the Commonwealth's role in providing consumer information on managed care issues; (iii) assesses the licensing functions for individual and institutional health care providers currently performed by the Department of Health Professions and the Department of Health, and determines, in light of current health care market conditions, whether any modification or consolidation of these functions would enhance the Commonwealth's efforts in overseeing the quality of managed care health plans; and (iv) evaluates whether there is a need to establish an external appeals or ombudsman process for resolving consumer complaints regarding managed care plans, and, if so, whether the Department of Health or another entity should administer the process. In formulating his recommendations, the State Health Commissioner is requested to optimize the contributions of other public and private entities such as Virginia Health Information, Inc.'s, role in consumer education, as well as identify other public and private partners able to support these functions.

3. That, in concert with the State Health Commissioner's examination of the quality of health care services provided by health maintenance organizations, the Department of Health be requested to receive and respond to complaints from managed care plan enrollees regarding quality of care issues which are forwarded to the Department by the Bureau of Insurance's consumer complaint review program.

CHAPTER 415

An Act to amend and reenact §§ 9-298 and 38.2-3431 of the Code of Virginia, relating to accident and sickness insurance; Special Advisory Commission on mandated health insurance benefits; provisions relating to accident and sickness insurance.

[H 2786]

Approved March 15, 1997

Be it enacted by the General Assembly of Virginia:

1. That §§9-298 and 38.2-3431 of the Code of Virginia are amended and reenacted as follows:

§9-298. Duties of the Special Advisory Commission; reimbursement.

A. The Special Advisory Commission shall:

1. Develop and maintain, with the Bureau of Insurance, a system and program of data collection to assess the impact of mandated benefits and providers, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers and other data as may be appropriate.

2. Advise and assist the Bureau of Insurance on matters relating to mandated insurance benefits and provider regulations.

3. Prescribe the format, content, and timing of information to be submitted to the Special Advisory Commission in its assessment of proposed and existing mandated benefits and providers. Such format, content, and timing requirements shall be binding upon all parties submitting information to the Special Advisory Commission in its assessment of proposed and existing mandated benefits and providers.

4. Provide assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the General Assembly.

5. Provide additional information and recommendations, relating to any system of mandated health insurance benefits and providers, to the Governor and the General Assembly upon request.

6. Report annually on its activities to the joint standing committees of the General Assembly having jurisdiction over insurance by December 1 of each year.

7. Review and evaluate as necessary the benefits and other provisions of the essential and standard health benefits plans established pursuant to § 38.2-3431, and submit to the State Corporation Commission, for adoption in the State Corporation Commission's applicable regulations pursuant to § 38.2-3431, any modifications needed to maintain or enhance the affordability and marketability of the plans.

B. Members of the Special Advisory Commission shall receive reimbursement for expenses incurred in the performance of their duties pursuant to Article 1 (§14.1-1 et seq.) of Chapter 1 of Title 14.1.

§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; *Medicaid coverage;* dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; 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 includ 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 *or the premium is paid by Medicaid through the Health Insurance Premium Payment Program.* 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 unde. the enrollee's prior plan.

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. *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 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 *regulations establishing or modifying the* 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 *regulations establishing or modifying the* 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.

10. 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 covere 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.

CHAPTER 913

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

[H 2887]
Approved April 2, 1997

Be it enacted by the General Assembly of Virginia:

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

Article 4.1. Individual Health Insurance Coverage.

§38.2-3430.1. Application of article.

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

§38.2-3430.2. Definitions.

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

B. For purposes of this article:

"Eligible individual" means an individual:

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

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

3. With respect to whom the most recent coverage within the coverage period described in subdivision 1 was not terminated based on a factor described in 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.

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

A. Guaranteed availability.

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

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

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

§38.2-3430.4. Special rules for network plans.

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

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

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

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

§38.2-3430.5. Application of financial capacity limits.

A. A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the health insurance issuer has demonstrated to the satisfaction of the Commission that:

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

2. It is applying this section uniformly to all individuals in the individual market in the Commonwealth consistent with the laws of this Commonwealth and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

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

§38.2-3430.6. Market requirements.

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

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

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

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

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

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

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

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

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

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

C. Requirements for uniform termination of coverage.

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

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

b. The health insurance issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the health insurance issuer for individuals in such market; and

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

2. Discontinuance of all coverage.

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

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

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

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

§38.2-3430.8. Certification of coverage.

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

§38.2-3430.9. Regulations establishing standards.

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

B. The Commission may revise or amend such regulations and may increase the scope of the regulations to the extent

necessary to maintain federal approval of the Commonwealth's program for regulation of health insurance issuers pursuant to the requirements established by the United States Department of Health and Human Services.

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

§38.2-3430.10. Effective date.

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

Article 5. ~~Small Employer Market Provisions.~~ *Group Market Reforms and Individual Coverage Offered to Employees of Small Employers.*

§38.2-3431. Application of article; definitions.

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

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

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

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

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

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

B. For the purposes of this article:

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

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

1. Such period shall begin on the enrollment date.

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

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

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

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

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

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

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

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

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

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

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

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

"COBRA continuation provision" means any of the following:

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

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

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

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

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

1. A group health plan;

2. Health insurance coverage;

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

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

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

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

7. A state health benefits risk pool;

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

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

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

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

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

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of thirty or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee.

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

1. In accordance with the terms of such plan;

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

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

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

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

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

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

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

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

1. Benefits not subject to requirements of this article:

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

b. Coverage issued as a supplement to liability insurance;

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

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

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

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

a. Limited scope dental or vision benefits;

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

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

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

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

b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

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

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

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

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

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

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

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

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

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

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

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

"Late enrollee" means ~~an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the health benefit plan.~~ *with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:*

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

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

"Medical care" means amounts paid for:

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

2. Amounts paid for transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Amounts paid for insurance covering medical care referred to in subdivisions 1 and 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Waiting period" means with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

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

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

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

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

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

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

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

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

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

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

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

3. ~~Within 180 days after the Commission's approval of essential and standard health benefit plans, every small employer carrier~~ *Every health insurance issuer offering group health insurance coverage* shall, as a condition of transacting business in Virginia with ~~primary~~ small employers, offer and make available to ~~primary~~ small employers an essential and a standard health benefit plan.

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

~~5.~~ *4.* All essential and standard benefit plans issued to ~~primary~~ small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium. A ~~small employer carrier~~ *health insurance issuer* shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by §38.2-316. Each rider, separate policy or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a ~~small employer carrier~~ *health*

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

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

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

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

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

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

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

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

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

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

d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than ~~ninety-nine~~ *fifty* eligible employees until the later of 180 days after closure to new applications or the date on which the ~~carrier~~ *health maintenance organization* notifies the Commission that it has regained capacity to deliver services to small employers. In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision ~~7~~ *6* of this subsection apply.

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

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

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

c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by

small employers to information concerning this article;

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

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

§38.2-3432.1. Renewability.

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

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

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

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

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

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

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

7. When a health insurance issuer offers health insurance coverage in the group market through a network plan, and there is no longer an enrollee in connection with such plan who lives, resides, or works in the service area of the health insurance issuer (or in the area for which the health insurance issuer is authorized to do business) and, in the case of the group market, the health insurance issuer would deny enrollment with respect to such plan under the provisions of 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 of this subsection in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market and this Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed;

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

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

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

B. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

§38.2-3432.2. Availability.

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

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

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

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

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

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

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

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

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

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

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

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

F. Nothing in this article shall be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules in connection with a health benefit plan offered in the small group market. As used in this article, the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of eligible individuals and the term "group participation rule" means a requirement relating to the minimum number of eligible employees that must be enrolled in relation to a specified percentage or number of eligible employees. Any employer contribution rule or group participation rule shall be applied uniformly among small employers without reference to the size of the small employer group, health status of the small employer group, or other factors.

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

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

1. Such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

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

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

B. Exceptions:

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

2. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

3. A health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition; and

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

C. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan, if, after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage.

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

E. Methods of crediting coverage:

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

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

3. In the case of an election with respect to a group plan under subdivision 2 of this subsection (whether or not health insurance coverage is provided in connection with such plan), the plan shall: (i) prominently state in any disclosure

statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election and (ii) include in such statements a description of the effect of this election; and

4. In the case of an election under subdivision 2 of this subsection with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall: (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election and (ii) include in such statements a description of the effect of such election.

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

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

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

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

3. At the request, or on behalf of, an individual made not later than twenty-four months after the date of cessation of the coverage described in 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 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.

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

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

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

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

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

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

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

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

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

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

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

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

3. Provisions affecting any preexisting conditions provision.

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

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

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

§38.2-3434. Disclosure of information.

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

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

§38.2-3435. Exclusions.

The provisions of this article shall not apply to:

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

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

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

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

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

§38.2-3436. Eligibility to enroll.

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

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

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

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

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

D. Nothing in subsection C shall be construed:

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

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

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

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

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

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

§38.2-4214. Application of certain provisions of law.

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

§38.2-4216.1. Open enrollment.

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

B. As used in this section, the term:

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

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

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

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

of such advertising shall be generally approved by the Commission.

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

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

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

§38.2-4217. Reports.

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

B. In addition to the annual statement required by §38.2-1300, the Commission shall require each nonstock corporation to file annually, on or before June 1, an annual statement, signed by two of its principal officers subject to §38.2-1304, showing:

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

a. Individual, open enrollment;

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

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

~~d. Associations;~~

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

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

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

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

§38.2-4229.1. Conversion to domestic mutual insurer.

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

B. Any nonstock corporation eligible to convert to a domestic mutual insurer under subsection A of this section may effect such conversion by amending its articles of incorporation to delete any reference to this chapter and to comply with the provisions of §38.2-1002 relating to the articles of incorporation of a domestic mutual insurer. Upon the issuance of a

certificate of amendment by the Commission, the conversion shall be effective, such nonstock corporation shall become subject to all of the provisions of this title relating to domestic mutual insurers, and, except as provided in subsection D of this section, such nonstock corporation shall no longer be subject to the provisions of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commission.

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

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

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

§38.2-4319. Statutory construction and relationship to other laws.

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

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

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

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

§38.2-4322. Affiliation period.

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

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

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

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

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

D. Defined terms as set forth in §38.2-3431 which are used in this chapter shall have the same meaning here that they have in Chapter 34.

§38.2-4323. Alternative methods.

A health maintenance organization may use alternative methods to an affiliation period to address adverse selection provided

that they are approved by the Commission prior to their use.

§58.1-2501. Levy of license tax.

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

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

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

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

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

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

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

3. That the Bureau of Insurance within the State Corporation Commission, in cooperation with the Joint Commission on Health Care, monitor the impact of the provisions of this act on the Commonwealth's health insurance marketplace. In monitoring the impact of this act, the State Corporation Commission shall: (i) review the federal regulations that will be promulgated to implement P.L. 104-191 (The Health Insurance Portability and Accountability Act of 1996), and determine whether any changes to this act are required by federal regulations adopted pursuant to P.L. 104-191; (ii) monitor the impact of the guaranteed issue requirements in the individual market and evaluate any specific concerns regarding such requirements identified and documented to the satisfaction of the State Corporation Commission by health insurance issuers; and (iii) recommend to the Governor and the 1998 Session of the General Assembly any revisions, corrections or improvements to the provisions of this act that would require the enactment of additional legislation.

SENATE JOINT RESOLUTION NO. 297

Directing the Joint Commission on Health Care to establish a task force to study the option of point-of-service plans for Virginia's businesses.

Agreed to by the Senate, February 12, 1997
Agreed to by the House of Delegates, February 10, 1997

WHEREAS, managed health care insurance plans have become the dominant form of health insurance across the nation and in the Commonwealth; and

WHEREAS, managed care plans seek to provide quality care and manage the cost of health care by arranging for specific types and amounts of health care services, and by coordinating patients' access to certain providers and health care services; and

WHEREAS, the number of persons enrolled in health maintenance organizations in Virginia has increased significantly in recent years and now totals nearly 1.4 million Virginians; and

WHEREAS, persons enrolled in closed panel health maintenance organizations generally do not receive benefits for services received from providers who are not in the health maintenance organization's provider panel; and

WHEREAS, some provider and consumer advocate groups have expressed concern that patients should be able to choose their own provider when accessing health care, and that the choice of providers available through closed panel health maintenance organizations is not sufficient; and

WHEREAS, point-of-service health insurance plans provide benefits for services received outside of a health maintenance organization's provider panel, albeit at a higher cost or lower level of coverage; and

WHEREAS, some provider and consumer groups have advocated that health maintenance organizations should be required to offer a point-of-service plan in addition to their traditional closed panel benefits plan as a means of enhancing patients' choice of providers, and that the choice of selecting a point-of-service plan should be made by the employee and not the employer; and

WHEREAS, these groups further advocate that any additional costs of offering a point-of-service plan should be borne by those enrollees who choose the point-of-service plan and not the health maintenance organization or the employer; and

WHEREAS, point-of-service plans are among the fastest growing type of managed care health insurance coverage in the United States; and

WHEREAS, representatives of the business and insurance communities believe that closed panel health maintenance organizations provide the most cost-effective health insurance coverage for employees; and

WHEREAS, House Bill No. 1393 of the 1996 Session of the General Assembly directed the Joint Commission on Health Care to study the need to require a point-of-service feature which would allow an enrollee the option to receive health care services outside a health maintenance organization's provider panel; and

WHEREAS, the Joint Commission on Health Care found that nearly all health maintenance organizations in Virginia offer point-of-service plans to employer groups, but was not able to determine the degree to which the choice of point-of-service plans is available at the employee level; and

WHEREAS, the joint commission heard concerns from the business and insurance communities regarding the various cost implications of such a mandate on small employers, including a concern that, due to adverse selection of risk to the point-of-service plan, actuarially, it would be difficult to isolate fully the additional costs associated with offering a point-of-service plan on those enrollees who select the point-of-service option without incurring higher costs for the employer and the health maintenance organization benefits plan; and

WHEREAS, while the joint commission supports enhancing patients' choice of providers, it is concerned about the potential financial impact on employers, particularly small employers, of requiring a point-of-service option at the employee level; and

WHEREAS, pooled purchasing arrangements such as health insurance purchasing cooperatives and alliances allow small employers to band together for the purposes of purchasing health insurance; and

WHEREAS, these arrangements allow small employers to enhance their purchasing power and provide employees with a greater choice of benefit options such as point-of-service plans at lower costs; and

WHEREAS, successful pooled purchasing arrangements exist in other states such as California and Florida where small employers are able to offer their employees a greater selection of benefit plans than would be possible outside of the purchasing arrangement; and

WHEREAS, the joint commission determined that further study is needed to resolve certain issues regarding the impact on employers of requiring point-of-service plans be offered to all employees, and to determine if other mechanisms such as pooled purchasing arrangements could enhance consumer choice of providers; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to establish a task force to study the option of point-of-service plans for Virginia's businesses. The task force shall be composed of members of the joint commission and representatives of consumers, providers, businesses, and insurers to develop options to enhance the opportunity of Virginia businesses to offer employees the option of participating in a point-of-service plan without increasing the employer's contribution to health benefits. The task force shall study various issues regarding a point-of-service requirement, including, but not limited to: (i) premium differentials and administrative charges of the closed panel HMO and point-of-service plans; (ii) copayments, deductibles and other cost-sharing arrangements; (iii) the comparability of benefit levels between the closed panel HMO and point-of-service plans; (iv) reimbursement of providers both within and outside of an HMO's provider panel; (v) participation levels or criteria and underwriting considerations; (vi) disclosure of information to patients; (vii) the process or conditions for employees selecting a point-of-service option; and (viii) whether the Employment Retirement Income Security Act (ERISA) or the Health Insurance Portability and Accountability Act of 1996 have any impact on a point-of-service requirement. In conducting its study the task force shall review and consider proposals for addressing the aforementioned issues submitted by the various interested parties.. The study shall include an actuarial analysis of how to isolate the additional cost of a point-of-service option on enrollees and whether such an approach can be implemented without increasing employers' cost of providing health benefits. The task force also shall examine other options for enhancing consumer choice of health benefit plans, including pooled purchasing. The study shall be conducted in cooperation with the Bureau of Insurance. Actuarial work, estimated at $100,000, will be required to complete this study.

The task force shall complete its work and present its findings and recommendations to the Joint Commission on Health Care by October 1, 1997. The joint commission shall submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 298

Directing the Joint Commission on Health Care, in cooperation with the Board and Department of Health, the Board and Department of Medical Assistance Services, the Commonwealth's academic health centers, and various governmental, public and private entities, to study the provision of health care for the indigent and uninsured.

Agreed to by the Senate, February 22, 1997
Agreed to by the House of Delegates, February 22, 1997

WHEREAS, indigent and uninsured Virginians are among the most vulnerable populations in terms of access to affordable, quality health care services; and

WHEREAS, research has found that persons without health insurance are less likely than those with insurance to receive needed medical services such as immunizations and routine check-ups, and, as a result, are more likely to develop conditions which could have been prevented or more successfully treated with early intervention and primary care; and

WHEREAS, within the health care marketplace, the indigent and uninsured often pay higher health care costs than persons with insurance because providers have negotiated contracts with insurers to provide services to their enrollees at a discounted price; and

WHEREAS, the provision and financing of health care services for the indigent and uninsured pose important and complex policy issues for state and local governments, the Commonwealth's academic health centers, and for businesses and health care providers; and

WHEREAS, the Virginia Indigent Health Care Trust Fund was established to help offset the expenses incurred by Virginia hospitals in providing care to the Commonwealth's indigent populations; and

WHEREAS, the limited funding available through the Indigent Health Care Trust Fund does not fully reimburse Virginia's hospitals for the total amount of indigent care provided; and

WHEREAS, the Indigent Health Care Trust Fund Technical Advisory Panel has been working for some time to establish a pilot program for subsidizing private health insurance for the working poor, but has not yet been successful in implementing the program; and

WHEREAS, the Commissioner of Health has announced that the Department of Health will sponsor a primary health care summit meeting in cooperation with public and private sector organizations to highlight innovative approaches which are expanding access to primary health care and to identify gaps that still need to be addressed; and

WHEREAS, a recent survey commissioned by the Virginia Health Care Foundation found that approximately 13 percent of Virginians, or 855,500 persons, have no health insurance of any kind; and

WHEREAS, an analysis of the survey data indicates that the percentage of the uninsured who are employed full time has increased 16 percent since 1993; and

WHEREAS, one of the founding purposes of the Joint Commission on Health Care was to ensure that the greatest number of Virginians receive quality, cost-effective health care services, including the indigent and uninsured populations; and

WHEREAS, during the past several years, there has been: (i) no analysis of the underlying reasons why persons are uninsured, (ii) no evaluation of current efforts and programs to reduce the number of uninsured Virginians and to provide services to the indigent, and (iii) no comprehensive analysis of new programs or policies to reduce the number of indigent and uninsured persons; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Board of Health, the Department of Health, the Board of Medical Assistance Services, the Department of Medical Assistance Services, the Commonwealth's academic health centers, various governmental entities study the provision of health care for the indigent and uninsured. The joint commission shall also confer with local governments, the Virginia Health Care Foundation, the Virginia Indigent Health Care Trust Fund Technical Advisory Panel, the Virginia Primary Care Association, and other appropriate public and private entities, regarding various issues related to the provision of health care for the indigent and uninsured.

The study shall include, but not be limited to: (i) an analysis of the recently completed survey on the insurance status of Virginians; (ii) an evaluation of the underlying reasons for persons being uninsured; (iii) an assessment of the impact that

not-for-profit to for-profit hospital conversions may be having on the indigent and uninsured; (iv) an assessment of the impact that the provision of care for these populations has on individual providers and hospitals, particularly the academic health centers; (v) an assessment of the role that projects supported by the Virginia Health Care Foundation and the Virginia Indigent Health Care Trust Fund play in meeting the needs of the uninsured; (vi) an evaluation of the appropriateness of expanding Medicaid coverage to certain segments of the uninsured population; (vii) an analysis of accessibility to child health preventive services; (viii) the analysis of the cause, prevalence, and impact of the inability of indigents to purchase prescribed medications, and (ix) an analysis of whether subsidies to purchase private health insurance should be implemented. As part of the study, the joint commission shall develop a program to be presented to the 1998 Session of the General Assembly and, if approved by the General Assembly, implemented by April 1, 1998, which will provide basic health insurance coverage for low-income, uninsured Virginians.

The joint commission shall submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 316

Directing the Joint Commission on Health Care to establish a task force to address outstanding long-term care and aging issues.

Agreed to by the Senate, February 17, 1997
Agreed to by the House of Delegates, February 13, 1997

WHEREAS, consistent with national trends, the Commonwealth's population is aging; and

WHEREAS, over the next decade, the Commonwealth's elderly population is expected to increase four times as rapidly as the general population; and

WHEREAS, the provision and financing of long-term care services to the elderly and chronically disabled populations is one of the most important public policy issues facing the Commonwealth; and

WHEREAS, it is important for federal, state, and local government long-term care policy regarding the provision and financing of services to recognize both the health care and social needs of the elderly and chronically disabled; and

WHEREAS, the ultimate goal of the long-term care system is to maintain the functional status of the elderly and chronically disabled populations; and

WHEREAS, long-term care and aging services should be delivered in the communities where the elderly and their families live; and

WHEREAS, the Commonwealth's policy for long-term care, as adopted by the 1993 General Assembly through House Joint Resolution No. 602, is to provide service to elderly individuals with programs and in settings which maximize their ability to function as independently as possible and which encourage the principles of personal dignity, a decent quality of life, individuality, privacy, and the right to make choices; and

WHEREAS, respite care is one method used to enable persons to stay in home settings and to avoid restrictive care as long as possible; and

WHEREAS, respite care works both for the client and the family by providing care, variety of schedule, and recreation; and

WHEREAS, respite care allows family and home caregivers to locate their loved ones in appropriate facilities for short periods of time when the caregivers cannot provide regular care; and

WHEREAS, respite care is being provided in a variety of long-term care settings; and

WHEREAS, long-term care insurance products are varied in what portions in the continuum of long-term care they cover; and

WHEREAS, the number of companies offering long-term care insurance and the number of policies sold continues to increase at a rapid rate, and such policies recently received favorable tax treatment from the 1996 "Kennedy-Kassebaum" health care reform bill; and

WHEREAS, long-term health care delivery has evolved and is now being provided in nursing facilities, assisted living facilities, and continuing care retirement communities; and

WHEREAS, regulatory provisions governing the construction and funding of long-term care beds must be designed to promote efficient and economic operation of these beds; and

WHEREAS, the complexity of the financing streams for long-term care services requires a careful and thorough analysis to ensure appropriate federal, state, and local government financing policy; and

WHEREAS, other states and the federal government are actively seeking ways to optimize the use of public funds to serve the growing elderly population; and

WHEREAS, a growing number of states are planning or implementing risk-based managed care programs for adults who are eligible for both Medicaid and Medicare; and

WHEREAS, the recently established Pre-PACE site in Virginia is a program which fully integrates the use of health care and long-term care dollars, provides a comprehensive package of services to persons living in the community, provides incentives for quality and cost control, and provides a service delivery model that may be applicable to other elderly, chronically ill, and younger populations; and

WHEREAS, any changes in the long-term care and aging service delivery systems should be accomplished in a manner that maximizes the efficiency and effectiveness of the existing system and should not shift costs to localities or require any unfunded mandates for localities; and

WHEREAS, two proposals have been recommended to consolidate and restructure certain functions of the various state agencies currently involved in planning, administering, managing, regulating, licensing and funding long-term care and aging services, and neither proposal has been implemented; and

WHEREAS, the lack of a centralized locus of responsibility has hindered Virginia's progress in long-term care service development; and

WHEREAS, consolidation of the acute and long-term care delivery system holds much promise in serving the elderly and disabled, but requires significant role differentiation among various public and private service providers at the local level; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to establish a task force to address outstanding long-term care issues pertaining to the licensing, financing, organization, and regulation of long-term care facilities and community-based services. In addition, the joint commission shall include in its deliberations study of additional ancillary long-term care issues such as the availability of and funding for respite care and the consistency to which long-term care insurance policies currently being offered in the Commonwealth meet the various needs of its citizens.

The joint commission's task force shall conduct its study in cooperation with the Secretary of Health and Human Resources; various state agencies, including the Department of Medical Assistance Services, the Department for the Aging, the State Department of Health, and the Department of Social Services; local governments; various long-term care and aging consumer and provider organizations; and other affected stakeholders.

An estimated $125,000 is allocated for the cost of staff or consultant support. Such expenses shall be funded by a separate appropriation by the General Assembly.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 317

Requesting the Secretary of Health and Human Resources, in cooperation with the Joint Commission on Health Care, to review the various boards, advisory boards, commissions, committees and councils identified by the Joint Commission on Health Care and recommend any appropriate revisions, consolidations or restructuring of these entities.

Agreed to by the Senate, January 30, 1997
Agreed to by the House of Delegates, February 13, 1997

WHEREAS, Senate Joint Resolution No. 104 of the 1996 Session of the General Assembly directed the Joint Commission on Health Care to review and make recommendations concerning the Commonwealth's numerous governmental, not-for-profit, and independent entities receiving state funds or having responsibilities for health care policy or regulation; and

WHEREAS, the Joint Commission on Health Care identified 63 such entities receiving state funds or having responsibility for health care policy or regulation, including various health care policy-setting boards, advisory boards, commissions, committees, and councils; and

WHEREAS, the Joint Commission on Health Care found that there is little interaction among the various boards, commissions, committees, and councils; and

WHEREAS, some of the existing entities meet very infrequently and some, such as the Virginia Health Planning Board and the Psychiatric Advisory Board, have not met in several years and may no longer need to be continued in their current capacity and structure; and

WHEREAS, there currently is no active entity within the Executive Branch of government with clear authority for coordinating statewide health policy; and

WHEREAS, there may be opportunities for revising, consolidating, or restructuring these entities; and

WHEREAS, most of the existing entities fall within the Secretariat of Health and Human Resources; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Secretary of Health and Human Resources, in cooperation with the Joint Commission on Health Care, be requested to review the various boards, advisory boards, commissions, committees, and councils identified by the Joint Commission on Health Care and recommend any appropriate revisions, consolidations, or restructuring of these entities.

The Secretary shall submit his findings and recommendations to the Governor and the Joint Commission on Health Care by October 15, 1997, and to the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 343

Memorializing Congress to proceed immediately with an extension of waivers to the Program for All Inclusive Care for the Elderly (PACE) program or to pass S. 999, extending provider status to the PACE program.

Agreed to by the Senate, January 30, 1997
Agreed to by the House of Delegates, February 20, 1997

WHEREAS, community-based services to the frail and chronically ill, especially to that category of elderly, are often uncoordinated, fragmented, inappropriate, or insufficient to meet the needs of the frail and chronically ill who are at risk of institutionalization, often resulting in unnecessary placement in nursing homes; and

WHEREAS, steadily increasing health care costs for the frail, chronically ill, and especially the frail elderly provide incentives to develop programs providing quality services at reasonable costs; and

WHEREAS, capitated, risk-based financing provides an alternative to the traditional fee-for-service payment system by providing a fixed, per capita monthly payment for a package of health care and social services and requires the provider to assume financial responsibility for cost overruns; and

WHEREAS, On Lok Senior Health Services of San Francisco, California, began as a federal and state demonstration program in 1973 to test whether comprehensive community-based services could be provided to the frail elderly at no greater cost than nursing home care; and

WHEREAS, since 1983, On Lok Senior Health Services of San Francisco, California, has successfully provided a comprehensive package of services and operated within a cost-effective, capitated risk-based financing system; and

WHEREAS, recognizing On Lok's success, Congress passed legislation in 1986, 1987, and 1990 encouraging the expansion of capitated long-term care programs by permitting federal Medicare and Medicaid waivers to be granted indefinitely to On Lok and authorizing the Health Care Financing Administration to grant waivers in up to 15 new sites throughout the nation in order to replicate the On Lok model and entitled this program as Program for All Inclusive Care for the Elderly (PACE); and

WHEREAS, in Virginia, the intent to develop programs similar to On Lok has been established by Chapter 628 (1996), which created insurance regulatory exemptions for certain health plans, and by the Budget Bill of 1995 I-92, 396-A-B; and

WHEREAS, pre-PACE sites can only transition to PACE if the program receives federal approval and no federal waivers are currently available; and

WHEREAS, Virginia's Medicaid program is currently in a contract with Sentara to offer services to Medicaid clients; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That Congress be urged to proceed immediately with an extension of waivers to the PACE program or to pass S. 999, extending provider status to the PACE program; and, be it

RESOLVED FURTHER, That the Clerk of the Senate transmit copies of this resolution to the President of the United States Senate, the Speaker of the House of Representatives, and the Congressional Delegation of Virginia in order that they may be apprised of the sense of the General Assembly in this matter.

HOUSE JOINT RESOLUTION NO. 551

Expressing the sense of the General Assembly that the strategic plan submitted by Virginia Health Information and the initiatives contained therein be supported by this body.

Agreed to by the House of Delegates, February 4, 1997
Agreed to by the Senate, February 19, 1997

WHEREAS, across the nation, both the public and private sectors have looked to health care cost and quality data reporting as a means of controlling health care costs and improving the quality of health care plans, providers and services; and

WHEREAS, it is important for health care consumers and purchasers to have useful information regarding health plans, providers and services in order to make informed health care decisions; and

WHEREAS, the Commonwealth has actively supported efforts to collect, analyze and publish valid, reliable health care cost and quality data to provide useful information to consumers, businesses, insurers and providers; and

WHEREAS, a 1995 study by the Joint Commission on Health Care found that most of the health care cost and quality data reports published by the former Virginia Health Services Cost Review Council had little value in the marketplace and that there was duplication and overlap in the functions and duties of the Virginia Health Services Cost Review Council and the private, nonprofit health data organization (Virginia Health Information), which was responsible for collecting data for the patient level data base system; and

WHEREAS, legislation passed by the 1996 Session of the General Assembly: (i) eliminated the Virginia Health Services Cost Review Council and the reports found not to be useful in the marketplace, (ii) transferred responsibility for administering the remaining health care data reports to the nonprofit health data organization through a contract with the State Department of Health, (iii) included health plans and physicians in the definition of health care provider; (iv) required the nonprofit health data organization's board of directors to evaluate the continued need for and efficacy of current data initiatives, and (v) required the nonprofit health data organization's board of directors to submit strategic plans, as appropriate, to the Board of Health, the Governor, and the General Assembly recommending specific data projects to be undertaken and specifying the data elements required of health care providers; and

WHEREAS, the first such strategic plan was to be submitted by October 1, 1996, and was to include recommendations for measuring quality of care for all health care providers and for funding all data projects undertaken; and

WHEREAS, the State Department of Health contracted with Virginia Health Information to perform the tasks of the nonprofit health data organization as required in the Code of Virginia; and

WHEREAS, the Board of Directors of Virginia Health Information, which is composed of representatives of businesses, consumers, physicians, nursing homes, health plans, and state government, developed its first strategic plan with considerable input from the interested stakeholders and in compliance with the provisions of §32.1-276.4 B 6 of the Code of Virginia; and

WHEREAS, Virginia Health Information's first strategic plan identifies a number of health data projects including: (i) expanding the patient level data system to include quality measures and health plan identifiers, (ii) continuing the efficiency and productivity methodology for hospitals and nursing homes and reviewing the efficacy of the methodology, (iii) developing general consumer publications on all provider types, (iv) developing consumer satisfaction measures for all types of health insurance plans, (v) publishing outcome information on obstetrics and cardiology services, (vi) developing potential uses of outpatient data, and (vii) forming a task force to develop a participative funding protocol to provide equitable funding by all stakeholders to fund data projects; and

WHEREAS, the President of Virginia Health Information's Board of Directors presented the strategic plan to the Joint Commission on Health Care at its October 24, 1996 meeting; and

WHEREAS, while some concerns were voiced regarding certain aspects of the strategic plan, overall, the public comments received by the Joint Commission on Health Care from interested parties and stakeholders indicated support for the strategic plan; and

WHEREAS, §32.1-276.4 B 6 of the Code of Virginia requires the approval of the General Assembly prior to the implementation of any recommendations set forth in a strategic plan submitted by the nonprofit health data organization; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the General Assembly support the strategic plan submitted by Virginia Health Information and the initiatives contained therein; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit copies of this resolution to the Governor, the Board of Health, the Commissioner of Health, and the President of Virginia Health Information in order that they may be apprised of the sense of the General Assembly in this matter.

HOUSE JOINT RESOLUTION NO. 611

Requesting the State Corporation Commission Bureau of Insurance, in cooperation with the State Department of Health, to review statutes and regulations governing health maintenance organizations and to determine the feasibility of their application to other forms of managed care health insurance plans.

Agreed to by the House of Delegates, February 4, 1997
Agreed to by the Senate, February 19, 1997

WHEREAS, the health insurance marketplace continues to change at a rapid pace in response to market demands for quality health care services at a reasonable cost; and

WHEREAS, managed care has become the dominant form of health insurance coverage in the United States and Virginia as evidenced by the increase in the number of employers offering managed care plans to their employees and the transition of many government-sponsored programs such as Medicare and Medicaid to managed care plans; and

WHEREAS, one of the goals of managed care health insurance plans is to provide quality care and at the same time control health care costs by coordinating the care received by patients and managing patients' access to providers and services; and

WHEREAS, a number of provider groups and consumer advocates have voiced concern regarding the degree to which some managed care insurance plans control patients' access to certain providers and services; and

WHEREAS, managed care originally encompassed only health maintenance organizations but now includes many different types of health insurance plans including preferred provider organizations, point-of-service plans and some managed indemnity benefit plans: and

WHEREAS, market trends indicate there will be a further proliferation of different forms of managed care plans in the near future; and

WHEREAS, a recent study conducted by the Joint Commission on Health Care regarding the Commonwealth's role in overseeing the managed care industry found that there are a number of state insurance laws and regulations contained in Chapter 43 (§38.2-4300 et seq.) of Title 38.2 that provide managed care protections which apply only to health maintenance organizations and not to other forms of managed care plans; and

WHEREAS, preferred provider organization and point-of-service plans include many of the same managed care features and requirements as health maintenance organizations; and

WHEREAS, given the changes that have occurred in the health care marketplace and the similarities that exist between health maintenance organizations and other forms of managed care plans, it may now be appropriate to have some provisions of Chapter 43 (§38.2-4300 et seq.) of Title 38.2 apply to other managed care insurance plans; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the State Corporation Commission Bureau of Insurance, in cooperation with the State Department of Health, be requested to review statutes and regulations governing health maintenance organizations and to determine the feasibility of their application to other forms of managed care health insurance plans. The Bureau is requested to: (i) identify the types of health insurance plans that should be considered as managed care plans; (ii) review the provisions of Chapter 43 (§38.2-4300 et seq.) of Title 38.2 and evaluate which provisions, if any, should apply to other forms of managed care health insurance plans such as preferred provider organizations and point-of-service plans; and (iii) identify any other appropriate provisions of the Code of Virginia or regulations promulgated by the Bureau that should apply to the types of health insurance plans identified as managed care plans.

The Bureau shall submit its findings and recommendations to the Joint Commission on Health Care by October 15, 1997, and to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 631

Directing the Joint Commission on Health Care to establish a task force to study the option of point-of-service plans for Virginia's businesses.

Agreed to by the House of Delegates, February 20, 1997
Agreed to by the Senate, February 19, 1997

WHEREAS, managed health care insurance plans have become the dominant form of health insurance across the nation and in the Commonwealth; and

WHEREAS, managed care plans seek to provide quality care and manage the cost of health care by arranging for specific types and amounts of health care services, and by coordinating patients' access to certain providers and health care services; and

WHEREAS, the number of persons enrolled in health maintenance organizations in Virginia has increased significantly in recent years and now totals nearly 1.4 million Virginians; and

WHEREAS, persons enrolled in closed panel health maintenance organizations generally do not receive benefits for services received from providers who are not in the health maintenance organization's provider panel; and

WHEREAS, some provider and consumer advocate groups have expressed concern that patients should be able to choose their own provider when accessing health care, and that the choice of providers available through closed panel health maintenance organizations is not sufficient; and

WHEREAS, point-of-service health insurance plans provide benefits for services received outside of a health maintenance organization's provider panel, albeit at a higher cost or lower level of coverage; and

WHEREAS, some provider and consumer groups have advocated that health maintenance organizations should be required to offer a point-of-service plan in addition to their traditional closed panel benefits plan as a means of enhancing patients' choice of providers, and that the choice of selecting a point-of-service plan should be made by the employee and not the employer; and

WHEREAS, these groups further advocate that any additional costs of offering a point-of-service plan should be borne by those enrollees who choose the point-of-service plan and not the health maintenance organization or the employer; and

WHEREAS, point-of-service plans are among the fastest growing type of managed care health insurance coverage in the United States; and

WHEREAS, representatives of the business and insurance communities believe that closed panel health maintenance organizations provide the most cost-effective health insurance coverage for employees; and

WHEREAS, House Bill No. 1393 of the 1996 Session of the General Assembly directed the Joint Commission on Health Care to study the need to require a point-of-service feature which would allow an enrollee the option to receive health care services outside a health maintenance organization's provider panel; and

WHEREAS, the Joint Commission on Health Care found that nearly all health maintenance organizations in Virginia offer point-of-service plans to employer groups, but was not able to determine the degree to which the choice of point-of-service plans is available at the employee level; and

WHEREAS, the joint commission heard concerns from the business and insurance communities regarding the various cost implications of such a mandate on small employers, including a concern that, due to adverse selection of risk to the point-of-service plan, actuarially, it would be difficult to isolate fully the additional costs associated with offering a point-of-service plan on those enrollees who select the point-of-service option without incurring higher costs for the employer and the health maintenance organization benefits plan; and

WHEREAS, while the joint commission supports enhancing patients' choice of providers, it is concerned about the potential financial impact on employers, particularly small employers, of requiring a point-of-service option at the employee level; and

WHEREAS, pooled purchasing arrangements such as health insurance purchasing cooperatives and alliances allow small employers to band together for the purposes of purchasing health insurance; and

WHEREAS, these arrangements allow small employers to enhance their purchasing power and provide employees with a greater choice of benefit options such as point-of-service plans at lower costs; and

WHEREAS, successful pooled purchasing arrangements exist in other states such as California and Florida where small employers are able to offer their employees a greater selection of benefit plans than would be possible outside of the purchasing arrangement; and

WHEREAS, the joint commission determined that further study is needed to resolve certain issues regarding the impact on employers of requiring point-of-service plans be offered to all employees, and to determine if other mechanisms such as pooled purchasing arrangements could enhance consumer choice of providers; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to establish a task force to study the option of point-of-service plans for Virginia's businesses. The task force shall be composed of members of the joint commission, and representatives of consumers, providers, businesses, and insurers to develop options to enhance the opportunity of Virginia's businesses to offer employees the option of participating in a point-of-service plan without increasing the employer's contribution to health benefits. The task force shall study various issues regarding a point-of-service requirement, including, but not limited to: (i) premium differentials and administrative charges of the closed panel HMO and point-of-service plans; (ii) copayments, deductibles and other cost-sharing arrangements; (iii) the comparability of benefit levels between the closed panel HMO and point-of-service plans; (iv) reimbursement of providers both within and outside of an HMO's provider panel; (v) participation levels or criteria and underwriting considerations; (vi) disclosure of information to patients; (vii) the process or conditions for employees selecting a point-of-service option; and (viii) whether the Employment Retirement Income Security Act (ERISA) or the Health Insurance Portability and Accountability Act of 1996 have any impact on a point-of-service requirement. In conducting its study the task force shall review and consider proposals for addressing the aforementioned issues submitted by the various interested parties. The study shall include an actuarial analysis of how to isolate the additional cost of a point-of-service option on enrollees and whether such an approach can be implemented without increasing employers' cost of providing health benefits. The task force also shall examine other options for enhancing consumer choice of health benefit plans, including pooled purchasing. The study shall be conducted in cooperation with the Bureau of Insurance. Actuarial work, estimated at $100,000, will be required to complete this study.

The task force shall complete its work and present its findings and recommendations to the Joint Commission on Health Care by October 1, 1997. The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 655

Directing the Joint Commission on Health Care to establish a task force to address outstanding long-term care and aging issues.

Agreed to by the House of Delegates, February 20, 1997
Agreed to by the Senate, February 19, 1997

WHEREAS, consistent with national trends, the Commonwealth's population is aging; and

WHEREAS, over the next decade, the Commonwealth's elderly population is expected to increase four times as rapidly as the general population; and

WHEREAS, the provision and financing of long-term care services to the elderly and chronically disabled populations is one of the most important public policy issues facing the Commonwealth; and

WHEREAS, it is important for federal, state, and local government long-term care policy regarding the provision and financing of services to recognize both the health care and social needs of the elderly and chronically disabled; and

WHEREAS, the ultimate goal of the long-term care system is to maintain the functional status of the elderly and chronically disabled populations; and

WHEREAS, long-term care and aging services should be delivered in the communities where the elderly and their families live; and

WHEREAS, the Commonwealth's policy for long-term care, as adopted by House Joint Resolution No. 602 (1993), is to provide service to elderly individuals with programs and in settings which maximize their ability to function as independently as possible and which encourage the principles of personal dignity, a decent quality of life, individuality, privacy, and the right to make choices; and

WHEREAS, respite care is one method used to enable persons to stay in home settings and to avoid restrictive care as long as possible; and

WHEREAS, respite care works both for the client and the family by providing care, variety of schedule, and recreation; and

WHEREAS, respite care allows family and home caregivers to locate their loved ones in appropriate facilities for short periods of time when the caregivers cannot provide regular care; and

WHEREAS, respite care is being provided in a variety of long-term care settings; and

WHEREAS, long-term care insurance products are varied in what portions in the continuum of long-term care they cover; and

WHEREAS, the number of companies offering long-term care insurance and the number of policies sold continues to increase at a rapid rate, and such policies recently received favorable tax treatment from the 1996 "Kennedy-Kassebaum" health care reform bill; and

WHEREAS, long-term health care delivery has evolved and is now being provided in nursing facilities, assisted living facilities, and continuing care retirement communities; and

WHEREAS, regulatory provisions governing the construction and funding of long-term care beds must be designed to promote efficient and economic operation of these beds; and

WHEREAS, the complexity of the financing streams for long-term care services requires a careful and thorough analysis to ensure appropriate federal, state, and local government financing policy; and

WHEREAS, other states and the federal government are actively seeking ways to optimize the use of public funds to serve the growing elderly population; and

WHEREAS, a growing number of states are planning or implementing risk-based managed care programs for adults who are eligible for both Medicaid and Medicare; and

WHEREAS, the recently established Pre-PACE site in Virginia is a program which fully integrates the use of health care and long-term care dollars, provides a comprehensive package of services to persons living in the community, provides incentives for quality and cost control, and provides a service delivery model that may be applicable to other elderly, chronically ill, and younger populations; and

WHEREAS, any changes in the long-term care and aging service delivery systems should be accomplished in a manner that maximizes the efficiency and effectiveness of the existing system and should not shift costs to localities or require any unfunded mandates for localities; and

WHEREAS, two proposals have been recommended to consolidate and restructure certain functions of the various state agencies currently involved in planning, administering, managing, regulating, licensing and funding long-term care and aging services, and neither proposal has been implemented; and

WHEREAS, the lack of a centralized locus of responsibility has hindered Virginia's progress in long-term care service development; and

WHEREAS, consolidation of the acute and long-term care delivery system holds much promise in serving the elderly and disabled, but requires significant role differentiation among various public and private service providers at the local level; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to establish a task force to address outstanding long-term care and aging issues pertaining to the licensing, financing, organization, and regulation of long-term care facilities and community-based services. In addition, the Commission shall include in its deliberations study of additional ancillary long-term care issues such as the availability of and funding for respite care and the consistency to which long-term care insurance policies currently being offered in the Commonwealth meet the various needs of its citizens.

The Commission's task force shall conduct its study in cooperation with the Secretary of Health and Human Resources; various state agencies, including the Department of Medical Assistance Services, the Department for the Aging, the State Department of Health, and the Department of Social Services; local governments; various long-term care and aging consumer and provider organizations; and other affected stakeholders.

An estimated $125,000 is allocated for the cost of staff or consultant support. Such expenses shall be funded by a separate appropriation by the General Assembly.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B:

1997 Workplan

JOINT COMMISSION ON HEALTH CARE

Proposed 1997 Meeting Schedule and Workplan

(Shaded Areas Represent JCHC Issue Briefs)

May 6th, 10:00 AM

- Status of DMAS' Contract For Medicaid Claims Payment System
- Status of 1997 Legislation
- 1997 Workplan
- Update on 1996 Survey on the Insurance Status of Virginians
- Overview of Workplan for Study of Indigent/Uninsured (SJR 298)
- Status Report on Department of Health's Study on Quality of Care Oversight (HB 2785)

June 3rd, 10:00 AM

- Indigent/Uninsured Study (SJR 298) Phase I Report (1st of 3 Reports)
- Status Report on Telemedicine Issues
- Overview of Workplan for Study of Long-Term Care and Aging Issues (SJR 316/HJR 655) and National Speaker

July 2nd, 10:00 AM

- Indigent/Uninsured Study (SJR 298)
  - Summary of Public Comments Received on Phase I Report
  - Phase II Report (2nd of 3 reports)
- Interim Report on "Point-of-Service" (POS) Study (SJR 297/HJR 631)
- Interim Report on Department of Health's Study on Quality of Care Oversight (HB 2785)

August 5th, 10:00 AM

- Indigent/Uninsured Study (SJR 298)
  - Summary of Public Comments Received on Phase II Report
  - Phase III Report (final report)
- Long-Term Care/Aging Study (SJR 316/HJR 655) Phase I Report (1st of 3 Reports)
- Status Report on AHEC Issues

September 16th, 10:00 AM

- Summary of Public Comments Received on Phase III Report of Indigent/Uninsured Study (SJR 298)
- Long-Term Care/Aging Study (SJR 316/HJR 655)
  - Summary of Public Comments Received on Phase I Report
  - Phase II Report (2nd of 3 reports)
- Report on Commissioner of Health's Primary Care Summit (Sept. 10 - 11)
- Study of the Health Status and Conditions of African-Americans in the Commonwealth (SJR 355)

October 7th, 10:00 AM

- Summary of Public Comments
  - Health Status and Conditions of African-Americans (SJR 355)
- Long-Term Care/Aging Study (SJR 316/HJR 655)
  - Summary of Public Comments Received on Phase II Report
  - Phase III Report (final report)
- Final Report on "Point-of-Service" (POS) Study (SJR 297/HJR 631)
  - Subcommittee Report
- Study of the Efficacy and Appropriateness of Establishing Minimum Standards for Hospital-Based Pediatric Care (HJR 569)
- Summary of Other Reports
  - Secretary of Health and Human Resources Study of Health-Related Boards, Commissions, and Councils (SJR 317)
  - Report of Commissioner of Health on Annual Review of COPN Program (HB 2477)
  - Virginia Health Information, Inc. (VHI) FY 1997 Annual Report

November 12th, 10:00 AM

- Summary of Public Comments
  - Phase III Report of Long-Term Care/Aging Study (SJR 316/HJR 655)
  - "Point-of-Service" Study (SJR 297/HJR 631)
  - Minimum Standards for Hospital-Based Pediatric Care (HJR 569)
  - Health-Related Boards, Commissions and Councils (SJR 317)
  - COPN Program Review (HB 2477)
- Subcommittee Reports
  - Indigent/Uninsured
  - Long-Term Care
- Study of High Risk Pools (SJR 337)
- Payment of Wellness Club Memberships for Medicaid Recipients (HB 2724)
- Bureau of Insurance Study on Managed Care Regulation (HJR 611)
- Discussion of Potential Group Accident & Sickness Insurance Statute Changes (Bureau of Insurance Proposals)
- Final Report on Department of Health's Study on Quality of Care Oversight (HB 2785)

December 2nd, 10:00 AM

- Summary of Public Comments
  - Study of High Risk Pools (SJR 337)
  - Payment of Wellness Club Memberships for Medicaid Recipients (HB 2724)
  - Bureau of Insurance Study on Managed Care Regulation (HJR 611)
  - Potential Group Accident & Sickness Insurance Statute Changes
  - Department of Health's Study on Quality of Care Oversight (HB 2785)
- Study of Pre-Existing Conditions and Community Rating in Health Insurance Policies (SB 1181)
- Department of Medical Assistance Services' (DMAS) Report on the Virginia Children's Medical Security Insurance Plan (HB 2682)
- Report of Maternal and Child Health Council On Access to Perinatal Care in Rural Areas (HJR 617)

December 2nd, 10:00 AM (Cont'd)

- Decision Matrix for Making Final Recommendations on JCHC Studies/Draft Legislative Proposals for Public Comment

January 6th, 10:00 AM

- Summary of Public Comments
    - Pre-Existing Conditions and Community Rating in Health Insurance Policies (SB 1181)
    - Virginia Children's Medical Security Insurance Plan (HB 2682)
    - Draft Legislative Proposals
- Approval of 1998 JCHC Legislative and Budgetary Recommendations
- Status Report on Medical Savings Accounts Task Force (SB 1035)
- Status Report on PACE Issues