HOUSE BILL NO. 884

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor

on _____)

(Patron Prior to Substitute--Delegate Byron)

A BILL to amend and reenact §§ 38.2-3420 and 38.2-3431 of the Code of Virginia and to amend the Code of Virginia by adding in Title 59.1 a chapter numbered 55, consisting of sections numbered 59.1-589 through 59.1-592, relating to group health benefit plans; sponsoring associations; formation of benefits consortium.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3420 and 38.2-3431 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 59.1 a chapter numbered 55, consisting of sections numbered 59.1-589 through 59.1-592, as follows:

§ 38.2-3420. Authority and jurisdiction of Commission; exception.

A. Except as provided in subsection ~~B~~ C, any person offering or providing coverage in the Commonwealth for health care services, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Commission to the extent the person is not regulated by another agency of the Commonwealth, any subdivision of the Commonwealth, or the federal government relating to the offering or providing of coverage for health care services.

B. As used in this subsection:

"Health benefit plan" has the same meaning as described in § 38.2-3431.

"Self-funded multiple employer welfare arrangement" or "self-funded MEWA" means any multiple employer welfare arrangement that is not fully insured by a licensed insurance company. This term includes a benefit consortium established under Chapter 55 (§ 59.1-589 et seq.) of Title 59.1.

1. No self-funded multiple employer welfare arrangement shall issue health benefit plans in the Commonwealth until it has obtained a license pursuant to regulations promulgated by the Commission.

No provision of this subsection shall authorize a self-funded MEWA domiciled outside of the Commonwealth to operate in the Commonwealth without obtaining a license pursuant to the regulations promulgated by the Commission.

2. Notwithstanding any other section of this title or Chapter 55 (§ 59.1-589 et seq.) of Title 59.1 to the contrary, all financial and solvency requirements imposed by provisions of this title upon domestic insurers shall apply to domestic self-funded MEWAs unless domestic self-funded MEWAs are otherwise specifically exempted. For the purposes of handling the rehabilitation, liquidation, or conservation of a domestic self-funded MEWA, the provisions of Chapter 15 (§ 38.2-1500 et seq.) shall apply.

3. Notwithstanding any other section of this title or Chapter 55 (§ 59.1-589 et seq.) of Title 59.1 to the contrary, any health benefit plan issued by a self-funded MEWA, including a trust, benefits consortium, or other arrangement, that covers one or more employees of one or more small employers shall (i) provide essential health benefits and cost-sharing requirements as set forth in § 38.2-3451; (ii) offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan; (iii) not limit or exclude coverage for an individual by imposing a preexisting condition exclusion on that individual pursuant to § 38.2-3444; (iv) not establish discriminatory rules based on health status related to eligibility or premium or contribution requirements as imposed on health carriers pursuant to § 38.2-3432.2; (v) meet the renewability standards set forth for health insurance issuers in § 38.2-3432.1; (vi) establish base rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all participant claims; and (vii) utilize each employer member's specific risk profile to determine premiums by actuarially adjusting above or below established base rates, and utilize either pooling or reinsurance of individual large claimants to reduce the adverse impact on any specific employer member's premiums.

4. The Commission shall have authority to adopt regulations applicable to self-funded MEWAs, whether domiciled inside or outside of the Commonwealth, including regulations addressing the self-funded MEWA's financial condition, solvency requirements, and insolvency plan and its exclusion, pursuant to § 59.1-592, from the Virginia Life, Accident and Sickness Insurance Guaranty Association established under Chapter 17 (§ 38.2-1700 et seq.).

C. Neither the provisions of this section nor any other provision of this title shall be construed to affect or apply to a multiple employer welfare arrangement (MEWA) ~~comprised~~ composed only of banks together with their plan-sponsoring organization, and their respective employees, provided the multiple employer welfare arrangement (i) is duly licensed as a MEWA by the insurance regulatory agency of a state contiguous to the Commonwealth, (ii) files with the Commission a copy of its certificate of authority or other proper license from the contiguous state, (iii) has no more than 500 Virginia residents who are employees of its member banks enrolled in or receiving accident and sickness benefits as insureds, members, enrollees, or subscribers of the MEWA, and (iv) is subject to solvency examination authority and reserve adequacy requirements determined by sound actuarial principles by such domiciliary contiguous state. For purposes of this subsection:

"Bank" means an institution that has or is eligible for insurance of deposits by the Federal Deposit Insurance Corporation.

"Plan-sponsoring organization" means an association that (i) sponsors a MEWA ~~comprised~~ composed only of banks; (ii) has been actively in existence for at least five years; (iii) has been formed and maintained in good faith for purposes other than obtaining insurance; (iv) 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; (v) 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; (vi) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and (vii) meets such additional requirements as may be imposed under the laws of the Commonwealth, and includes any subsidiary of such an association.

§ 38.2-3431. Application of article; definitions.

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

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each

corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in ~~this~~ the Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met:

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

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

3. The employer has permitted payroll deduction for the covered individual and any portion of the premium is paid by the employer, provided that the health insurance issuer providing individual coverage under such circumstances shall be registered as a health insurance issuer in the small group market under this article, and shall have offered small employer group insurance to the employer in the manner required under this article; or

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

B. For the purposes of this article:

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

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

1. Such period shall begin on the enrollment date.

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

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

"Bona fide association" means, with respect to health insurance coverage offered in ~~this~~ the 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~~ the Commonwealth.

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

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

"COBRA continuation provision" means any of the following:

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

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

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

"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 XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);

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

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

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

7. A state health benefits risk pool;

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

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

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

11. Individual health insurance coverage.

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 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. At the employer's sole discretion, the eligibility criterion may be broadened to include part-time employees.

"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~~ the 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.

"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; 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; 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~~ the Commonwealth and which is subject to the laws of ~~this~~ the 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~~ the Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of ~~this~~ the 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.

"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 51 employees on business days during the preceding calendar year and who employs at least one employee 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.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

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

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

"Medical care" means amounts paid for:

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

2. Transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Insurance covering medical care referred to in subdivisions 1 and 2.

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

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

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

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

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

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

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

"Rating period" means the 12-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

"Self-employed individual" means an individual who derives a substantial portion of his income from a trade or business (i) operated by the individual as a sole proprietor, (ii) through which the individual has attempted to earn taxable income, and (iii) for which he has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

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

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In determining whether a corporation or limited liability company employed an average of at least one individual during the preceding calendar year and employed at least one employee on the first day of the plan year, an individual who performed any service for remuneration under a contract of hire, written or oral, express or implied, for a (i) corporation of which the individual is a shareholder or an immediate family member of a shareholder or (ii) a limited liability company of which the individual is a member shall be deemed to be an employee of the corporation or the limited liability company, respectively. However, a health insurance issuer shall not be required to issue more than one group health plan for each employer identification number issued by the Internal Revenue Service for a business entity, without regard to the number of shareholders or members of such business entity. "Small employer" includes a self-employed individual.

"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.

"Sponsoring association" means a nonstock corporation formed under the Virginia Nonstock Corporation Act (§ 13.1-801 et seq.) that:

1. Has been formed and maintained in good faith for purposes other than obtaining or providing health benefits;

2. Does not condition membership in the sponsoring association on any factor relating to the health status of an individual, including an employee of an employer member of the sponsoring association or a dependent of such an employee;

3. Makes any health benefit plan available to all members regardless of any factor relating to the health status of such members or individuals eligible for coverage through another member;

4. Does not make any health benefit plan available to any person who is not a member of the association;

5. Makes available health plans or health benefit plans that meet the requirements for health benefit plans set forth in subdivision B 3 of § 38.2-3420;

6. Operates as a nonprofit entity under § 501(c)(5) or 501(c)(6) of the Internal Revenue Code;

7. Has been in active existence for at least five years; and

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

"Sponsoring association" includes any wholly owned subsidiary of a sponsoring association.

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

"Waiting period" means, with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. If an employee or dependent enrolls during a special enrollment period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such enrollment is not a waiting period.

C. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

CHAPTER 55.

BENEFITS CONSORTIUM.

§ 59.1-589. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Benefits consortium" means a trust that is a self-funded MEWA, as defined in § 38.2-3420, and that complies with the conditions set forth in § 59.1-590.

"ERISA" means the federal Employee Retirement Income Security Act of 1974, P.L. 93-406, 88 Stat. 829, as amended.

"Health benefit plan" has the same meaning as in § 38.2-3431.

"Member" means a person that is part of a sponsoring association, that conducts business operations within the Commonwealth, and that employs individuals who reside in the Commonwealth.

"Sponsoring association" has the same meaning as in § 38.2-3431 and includes any wholly owned subsidiary of a sponsoring association.

"Trust" means a trust that (i) is established to accept and hold assets of a health benefit plan in trust in accordance with the terms of the written trust document for the sole purposes of providing medical, prescription drug, dental, and vision benefits and defraying reasonable administrative costs of providing health benefits under a health benefit plan and (ii) complies with the conditions set forth in § 59.1-590.

§ 59.1-590. Conditions for a benefits consortium.

A. This section does not apply to a multiple employer welfare arrangement (MEWA) that offers or provides health benefit plans that are fully insured by an insurer authorized to transact the business of health insurance in the Commonwealth.

B. A trust shall constitute a benefits consortium and shall be authorized to sell or offer to sell health benefit plans to members of a sponsoring association in accordance with the provisions of this chapter if all of the following conditions are satisfied:

1. The trust shall be subject to (i) ERISA and U.S. Department of Labor regulations applicable to multiple employer welfare arrangements and (ii) the authority of the U.S. Department of Labor to enforce such law and regulations;

2. A Form M-1, Report for Multiple Employer Welfare Arrangements (MEWAs), for the applicable plan year shall be filed with the U.S. Department of Labor identifying the arrangement among the trust, sponsoring association, and health benefit plans offered through the trust as a multiple employer welfare arrangement;

3. The trust's organizational documents shall:

a. Provide that the trust is sponsored by the sponsoring association;

b. State that the purpose of the trust is to provide medical, prescription drug, dental, and vision benefits to participating employees of the sponsoring association or its members, and the dependents of those employees, through health benefit plans;

c. Provide that the funds of the trust are to be used for the benefit of participating employees, and the dependents of those employees, through self-funding of claims, the purchase of reinsurance, or a combination thereof, as determined by the trustee, and for defraying reasonable expenses of administering and operating the trust and any health benefit plan;

d. Limit participation in health benefit plans to participating employees of the sponsoring association and its members;

e. Provide for a board of trustees, composed of no fewer than five trustees, that has complete fiscal control over the arrangement and is responsible for all operations of the arrangement. The trustees selected for the board shall be owners, partners, officers, directors, or employees of one or more employers in the arrangement. A trustee or director may not be an owner, officer, or employee of the administrator or service company of the arrangement. The board shall have the authority to approve applications of association members for participation in the arrangement and to contract with a licensed administrator or service company to administer the day-to-day affairs of the arrangement;

f. Provide for the election of trustees to the board of trustees; and

g. Require the trustees to discharge their duties with respect to the trust in accordance with the fiduciary duties defined in ERISA;

4. Five or more members shall participate in one or more health benefit plans;

5. The trust shall establish and maintain reserves determined in accordance with sound actuarial principles and in compliance with all financial and solvency requirements imposed upon domestic self-funded MEWAs;

6. The trust shall purchase and maintain policies of specific, aggregate, and terminal excess insurance with retention levels determined in accordance with sound actuarial principles from insurers licensed to transact the business of insurance in the Commonwealth;

7. The trust shall secure one or more guarantees or standby letters of credit that:

a. Guarantee the payment of claims under the health benefit plan in an aggregate amount not less than the amount of the trust's annual aggregate excess insurance retention level minus (i) the annual premium assessments for the health benefit plans and (ii) the trust's net assets, which amount shall be the net of the trust's reasonable estimate of incurred but not reported claims; and

b. Have been issued by a qualified United States financial institution, as such term is used in subdivision 2 c of § 38.2-1316.4;

8. The trust shall purchase and maintain commercially reasonable fiduciary liability insurance;

9. The trust shall purchase and maintain a bond that satisfies the requirements of ERISA;

10. The trust is audited annually by an independent certified public accountant; and

11. The trust does not include in its name the words "insurance," "insurer," "underwriter," "mutual," or any other word or term or combination of words or terms that is uniquely descriptive of an insurance company or insurance business unless the context of the remaining words or terms clearly indicates that the entity is not an insurance company and is not transacting the business of insurance.

§ 59.1-591. Additional requirements.

A. The board of trustees established pursuant to subsection B of § 59.1-590 shall (i) operate any health benefit plans in accordance with the fiduciary duties defined in ERISA and (ii) have the power to make and collect special assessments against members and, if any assessment is not timely paid, to enforce collection of such assessment.

B. Each member shall be liable for his allocated share of the liabilities of the sponsoring association under a health benefit plan as determined by the board of trustees.

C. Health benefit plan documents shall have the following statement printed on the first page in size 14-point boldface type:

"This coverage is not insurance and is not offered through an insurance company. This coverage is not required to comply with certain federal market requirements for health insurance, nor is it required to comply with certain state laws for health insurance. Each member shall be liable for his allocated share of the liabilities of the sponsoring association under the health benefit plan as determined by the board of trustees. This means that each member may be responsible for paying an additional sum if the annual premiums present a deficit of funds for the trust. The trust's financial documents shall be available for public inspection at (insert website of where sponsoring association trust documents are posted)."

§ 59.1-592. Exemptions; license tax.

Notwithstanding any other provision of law, a benefits consortium or sponsoring association, by virtue of its sponsorship of a benefits consortium or any health benefit plan, shall not be subject to the following: (i) the provisions of Chapter 17 (§ 38.2-1700 et seq.) of Title 38.2 or any regulations adopted thereunder or (ii) any annual license tax levied pursuant to § 58.1-2501.

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