SENATE BILL NO. 195

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Commerce and Energy

on ________________)

(Patrons Prior to Substitute--Senators Mason and Dunnavant [SB 549])

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.

27 No provision of this subsection shall authorize a self-funded MEWA domiciled outside of the
28 Commonwealth to operate in the Commonwealth without obtaining a license pursuant to the regulations
29 promulgated by the Commission.
30 2. Notwithstanding any other section of this title or Chapter 55 (§ 59.1-589 et seq.) of Title 59.1
31 to the contrary, all financial and solvency requirements imposed by provisions of this title upon domestic
32 insurers shall apply to domestic self-funded MEWAs unless domestic self-funded MEWAs are otherwise
33 specifically exempted. For the purposes of handling the rehabilitation, liquidation, or conservation of a
34 domestic self-funded MEWA, the provisions of Chapter 15 (§ 38.2-1500 et seq.) shall apply.
35 3. Notwithstanding any other section of this title or Chapter 55 (§ 59.1-589 et seq.) of Title 59.1
36 to the contrary, any health benefit plan issued by a self-funded MEWA, including a trust, benefits
37 consortium, or other arrangement, that covers one or more employees of one or more small employers
38 shall (i) provide essential health benefits and cost-sharing requirements as set forth in § 38.2-3451; (ii)
39 offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60
40 percent of the full actuarial value of the benefits provided under the plan; (iii) not limit or exclude coverage
41 for an individual by imposing a preexisting condition exclusion on that individual pursuant to § 38.2-
42 3444; (iv) not establish discriminatory rules based on health status related to eligibility or premium or
43 contribution requirements as imposed on health carriers pursuant to § 38.2-3432.2; (v) meet the
44 renewability standards set forth for health insurance issuers in § 38.2-3432.1; (vi) establish base rates
45 formed on an actuarially sound, modified community rating methodology that considers the pooling of all
46 participant claims; and (vii) utilize each employer member's specific risk profile to determine premiums
47 by actuarially adjusting above or below established base rates, and utilize either pooling or reinsurance of
48 individual large claimants to reduce the adverse impact on any specific employer member's premiums.
49 4. The Commission shall have authority to adopt regulations applicable to self-funded MEWAs,
50 whether domiciled inside or outside of the Commonwealth, including regulations addressing the self-
51 funded MEWA's financial condition, solvency requirements, and insolvency plan and its exclusion,
52 pursuant to § 59.1-592, from the Virginia Life, Accident and Sickness Insurance Guaranty Association
53 established under Chapter 17 (§ 38.2-1700 et seq.).

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

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

66 "Plan-sponsoring organization" means an association that (i) sponsors a MEWA ~~comprised~~
67 composed only of banks; (ii) has been actively in existence for at least five years; (iii) has been formed
68 and maintained in good faith for purposes other than obtaining insurance; (iv) does not condition
69 membership in the association on any health status-related factor relating to an individual, including an
70 employee of an employer or a dependent of an employee; (v) makes health insurance coverage offered
71 through the association available to all members regardless of any health status-related factor relating to
72 such members or individuals eligible for coverage through a member; (vi) does not make health insurance
73 coverage offered through the association available other than in connection with a member of the
74 association; and (vii) meets such additional requirements as may be imposed under the laws of the
75 Commonwealth, and includes any subsidiary of such an association.

76 **§ 38.2-3431. Application of article; definitions.**

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

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

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

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

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

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

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

97 B. For the purposes of this article:

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

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

108 1. Such period shall begin on the enrollment date.
109 2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.
110 "Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement
111 Income Security Act of 1974 (29 U.S.C. § 1002 (8)).
112 "Bona fide association" means, with respect to health insurance coverage offered in ~~this~~ the
113 Commonwealth, an association which:
114 1. Has been actively in existence for at least five years;
115 2. Has been formed and maintained in good faith for purposes other than obtaining insurance;
116 3. Does not condition membership in the association on any health status-related factor relating to
117 an individual (including an employee of an employer or a dependent of an employee);
118 4. Makes health insurance coverage offered through the association available to all members
119 regardless of any health status-related factor relating to such members (or individuals eligible for coverage
120 through a member);
121 5. Does not make health insurance coverage offered through the association available other than
122 in connection with a member of the association; and
123 6. Meets such additional requirements as may be imposed under the laws of ~~this~~ the
124 Commonwealth.
125 "Certification" means a written certification of the period of creditable coverage of an individual
126 under a group health plan and coverage provided by a health insurance issuer offering group health
127 insurance coverage and the coverage if any under such COBRA continuation provision, and the waiting
128 period if any and affiliation period if applicable imposed with respect to the individual for any coverage
129 under such plan.
130 "Church plan" has the meaning given such term under section 3(33) of the Employee Retirement
131 Income Security Act of 1974 (29 U.S.C. § 1002 (33)).
132 "COBRA continuation provision" means any of the following:
133 1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection
134 (f)(1) of such section insofar as it relates to pediatric vaccines;

135 2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29
136 U.S.C. § 1161 et seq.), other than section 609 of such Act; or
137 3. Title XXII of P.L. 104-191.
138 "Creditable coverage" means with respect to an individual, coverage of the individual under any
139 of the following:
140 1. A group health plan;
141 2. Health insurance coverage;
142 3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);
143 4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting
144 solely of benefits under section 1928;
145 5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);
146 6. A medical care program of the Indian Health Service or of a tribal organization;
147 7. A state health benefits risk pool;
148 8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);
149 9. A public health plan (as defined in federal regulations);
150 10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)); or
151 11. Individual health insurance coverage.
152 Such term does not include coverage consisting solely of coverage of excepted benefits.
153 "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of
154 the policy, contract or plan covering the eligible employee.
155 "Eligible employee" means an employee who works for a small group employer on a full-time
156 basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements,
157 and is not a part-time, temporary or substitute employee. At the employer's sole discretion, the eligibility
158 criterion may be broadened to include part-time employees.
159 "Eligible individual" means such an individual in relation to the employer as shall be determined:
160 1. In accordance with the terms of such plan;

161 2. As provided by the health insurance issuer under rules of the health insurance issuer which are
162 uniformly applicable to employers in the group market; and
163 3. In accordance with all applicable law of ~~this~~ the Commonwealth governing such issuer and such
164 market.
165 "Employee" has the meaning given such term under section 3(6) of the Employee Retirement
166 Income Security Act of 1974 (29 U.S.C. § 1002 (6)).
167 "Employer" has the meaning given such term under section 3(5) of the Employee Retirement
168 Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers
169 of two or more employees.
170 "Enrollment date" means, with respect to an eligible individual covered under a group health plan
171 or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or,
172 if earlier, the first day of the waiting period for such enrollment.
173 "Excepted benefits" means benefits under one or more (or any combination thereof) of the
174 following:
175 1. Benefits not subject to requirements of this article:
176 a. Coverage only for accident, or disability income insurance, or any combination thereof;
177 b. Coverage issued as a supplement to liability insurance;
178 c. Liability insurance, including general liability insurance and automobile liability insurance;
179 d. Workers' compensation or similar insurance;
180 e. Medical expense and loss of income benefits;
181 f. Credit-only insurance;
182 g. Coverage for on-site medical clinics; and
183 h. Other similar insurance coverage, specified in regulations, under which benefits for medical
184 care are secondary or incidental to other insurance benefits.
185 2. Benefits not subject to requirements of this article if offered separately:
186 a. Limited scope dental or vision benefits;

187 b. Benefits for long-term care, nursing home care, home health care, community-based care, or
188 any combination thereof; and
189 c. Such other similar, limited benefits as are specified in regulations.
190 3. Benefits not subject to requirements of this article if offered as independent, noncoordinated
191 benefits:
192 a. Coverage only for a specified disease or illness; and
193 b. Hospital indemnity or other fixed indemnity insurance.
194 4. Benefits not subject to requirements of this article if offered as separate insurance policy:
195 a. Medicare supplemental health insurance (as defined under section 1882 (g)(1) of the Social
196 Security Act (42 U.S.C. § 1395ss (g)(1));
197 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States
198 Code (10 U.S.C. § 1071 et seq.); and
199 c. Similar supplemental coverage provided to coverage under a group health plan.
200 "Federal governmental plan" means a governmental plan established or maintained for its
201 employees by the government of the United States or by an agency or instrumentality of such government.
202 "Governmental plan" has the meaning given such term under section 3(32) of the Employee
203 Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.
204 "Group health insurance coverage" means in connection with a group health plan, health insurance
205 coverage offered in connection with such plan.
206 "Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the
207 Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan
208 provides medical care and including items and services paid for as medical care to employees or their
209 dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or
210 otherwise.
211 "Health benefit plan" means any accident and health insurance policy or certificate, health services
212 plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan
213 provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or

214 disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts
215 with the United States government; Medicare supplement or long-term care insurance; Medicaid
216 coverage; dental only or vision only insurance; specified disease insurance; hospital confinement
217 indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability
218 insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment
219 insurance; medical expense and loss of income benefits; or insurance under which benefits are payable
220 with or without regard to fault and that is statutorily required to be contained in any liability insurance
221 policy or equivalent self-insurance.

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

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

231 "Health maintenance organization" means:

232 1. A federally qualified health maintenance organization;

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

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

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

240 1. Health status;

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

242 3. Claims experience;

243 4. Receipt of health care;

244 5. Medical history;

245 6. Genetic information;

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

247 8. Disability.

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

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

253 "Large employer" means, in connection with a group health plan or health insurance coverage with
254 respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees
255 on business days during the preceding calendar year and who employs at least one employee on the first
256 day of the plan year.

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

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

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

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

265 "Medical care" means amounts paid for:

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

268 2. Transportation primarily for and essential to medical care referred to in subdivision 1; and
269 3. Insurance covering medical care referred to in subdivisions 1 and 2.
270 "Network plan" means health insurance coverage of a health insurance issuer under which the
271 financing and delivery of medical care (including items and services paid for as medical care) are
272 provided, in whole or in part, through a defined set of providers under contract with the health insurance
273 issuer.
274 "Nonfederal governmental plan" means a governmental plan that is not a federal governmental
275 plan.
276 "Participant" has the meaning given such term under section 3(7) of the Employee Retirement
277 Income Security Act of 1974 (29 U.S.C. § 1002 (7)).
278 "Placed for adoption," or "placement" or "being placed" for adoption, in connection with any
279 placement for adoption of a child with any person, means the assumption and retention by such person of
280 a legal obligation for total or partial support of such child in anticipation of adoption of such child. The
281 child's placement with such person terminates upon the termination of such legal obligation.
282 "Plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee
283 Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16)(B)).
284 "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of
285 benefits relating to a condition based on the fact that the condition was present before the date of
286 enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was
287 recommended or received before such date. Genetic information shall not be treated as a preexisting
288 condition in the absence of a diagnosis of the condition related to such information.
289 "Premium" means all moneys paid by an employer and eligible employees as a condition of
290 coverage from a health insurance issuer, including fees and other contributions associated with the health
291 benefit plan.
292 "Rating period" means the 12-month period for which premium rates are determined by a health
293 insurance issuer and are assumed to be in effect.

294 "Self-employed individual" means an individual who derives a substantial portion of his income
295 from a trade or business (i) operated by the individual as a sole proprietor, (ii) through which the individual
296 has attempted to earn taxable income, and (iii) for which he has filed the appropriate Internal Revenue
297 Service Form 1040, Schedule C or F, for the previous taxable year.
298 "Service area" means a broad geographic area of the Commonwealth in which a health insurance
299 issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization
300 to do business in Virginia.
301 "Small employer" means in connection with a group health plan or health insurance coverage with
302 respect to a calendar year and a plan year, an employer who employed an average of at least one but not
303 more than 50 employees on business days during the preceding calendar year and who employs at least
304 one employee on the first day of the plan year. In determining whether a corporation or limited liability
305 company employed an average of at least one individual during the preceding calendar year and employed
306 at least one employee on the first day of the plan year, an individual who performed any service for
307 remuneration under a contract of hire, written or oral, express or implied, for a (i) corporation of which
308 the individual is a shareholder or an immediate family member of a shareholder or (ii) a limited liability
309 company of which the individual is a member shall be deemed to be an employee of the corporation or
310 the limited liability company, respectively. However, a health insurance issuer shall not be required to
311 issue more than one group health plan for each employer identification number issued by the Internal
312 Revenue Service for a business entity, without regard to the number of shareholders or members of such
313 business entity. "Small employer" includes a self-employed individual.
314 "Small group market" means the health insurance market under which individuals obtain health
315 insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents)
316 through a group health plan maintained by a small employer.
317 "Sponsoring association" means a nonstock corporation formed under the Virginia Nonstock
318 Corporation Act (§ 13.1-801 et seq.) that:
319 1. Has been formed and maintained in good faith for purposes other than obtaining or providing
320 health benefits;

321 2. Does not condition membership in the sponsoring association on any factor relating to the health
322 status of an individual, including an employee of an employer member of the sponsoring association or a
323 dependent of such an employee;
324 3. Makes any health benefit plan available to all members regardless of any factor relating to the
325 health status of such members or individuals eligible for coverage through another member;
326 4. Does not make any health benefit plan available to any person who is not a member of the
327 association;
328 5. Makes available health plans or health benefit plans that meet the requirements for health benefit
329 plans set forth in subdivision B 3 of § 38.2-3420;
330 6. Operates as a nonprofit entity under § 501(c)(5) or 501(c)(6) of the Internal Revenue Code;
331 7. Has been in active existence for at least five years; and
332 8. Meets such additional requirements as may be imposed under the laws of the Commonwealth.
333 "Sponsoring association" includes any wholly owned subsidiary of a sponsoring association.
334 "State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands,
335 Guam, American Samoa, and the Northern Mariana Islands.
336 "Waiting period" means, with respect to a group health plan or health insurance coverage provided
337 by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the
338 period that must pass with respect to the individual before the individual is eligible to be covered for
339 benefits under the terms of the plan. If an employee or dependent enrolls during a special enrollment
340 period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such
341 enrollment is not a waiting period.
342 C. The provisions of this section shall not apply in any instance in which the provisions of this
343 section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.
344 CHAPTER 55.
345 BENEFITS CONSORTIUM.
346 **§ 59.1-589. Definitions.**
347 As used in this chapter, unless the context requires a different meaning:

348 "Benefits consortium" means a trust that is a self-funded MEWA, as defined in § 38.2-3420, and
349 that complies with the conditions set forth in § 59.1-590.
350 "ERISA" means the federal Employee Retirement Income Security Act of 1974, P.L. 93-406, 88
351 Stat. 829, as amended.
352 "Health benefit plan" has the same meaning as in § 38.2-3431.
353 "Member" means a person that is part of a sponsoring association, that conducts business
354 operations within the Commonwealth, and that employs individuals who reside in the Commonwealth.
355 "Sponsoring association" has the same meaning as in § 38.2-3431 and includes any wholly owned
356 subsidiary of a sponsoring association.
357 "Trust" means a trust that (i) is established to accept and hold assets of a health benefit plan in trust
358 in accordance with the terms of the written trust document for the sole purposes of providing medical,
359 prescription drug, dental, and vision benefits and defraying reasonable administrative costs of providing
360 health benefits under a health benefit plan and (ii) complies with the conditions set forth in § 59.1-590.
361 **§ 59.1-590. Conditions for a benefits consortium.**
362 A. This section does not apply to a multiple employer welfare arrangement (MEWA) that offers
363 or provides health benefit plans that are fully insured by an insurer authorized to transact the business of
364 health insurance in the Commonwealth.
365 B. A trust shall constitute a benefits consortium and shall be authorized to sell or offer to sell health
366 benefit plans to members of a sponsoring association in accordance with the provisions of this chapter if
367 all of the following conditions are satisfied:
368 1. The trust shall be subject to (i) ERISA and U.S. Department of Labor regulations applicable to
369 multiple employer welfare arrangements and (ii) the authority of the U.S. Department of Labor to enforce
370 such law and regulations;
371 2. A Form M-1, Report for Multiple Employer Welfare Arrangements (MEWAs), for the
372 applicable plan year shall be filed with the U.S. Department of Labor identifying the arrangement among
373 the trust, sponsoring association, and health benefit plans offered through the trust as a multiple employer
374 welfare arrangement;

375 3. The trust's organizational documents shall:
376 a. Provide that the trust is sponsored by the sponsoring association;
377 b. State that the purpose of the trust is to provide medical, prescription drug, dental, and vision
378 benefits to participating employees of the sponsoring association or its members, and the dependents of
379 those employees, through health benefit plans;
380 c. Provide that the funds of the trust are to be used for the benefit of participating employees, and
381 the dependents of those employees, through self-funding of claims, the purchase of reinsurance, or a
382 combination thereof, as determined by the trustee, and for defraying reasonable expenses of administering
383 and operating the trust and any health benefit plan;
384 d. Limit participation in health benefit plans to participating employees of the sponsoring
385 association and its members;
386 e. Provide for a board of trustees, composed of no fewer than five trustees, that has complete fiscal
387 control over the arrangement and is responsible for all operations of the arrangement. The trustees selected
388 for the board shall be owners, partners, officers, directors, or employees of one or more employers in the
389 arrangement. A trustee or director may not be an owner, officer, or employee of the administrator or
390 service company of the arrangement. The board shall have the authority to approve applications of
391 association members for participation in the arrangement and to contract with a licensed administrator or
392 service company to administer the day-to-day affairs of the arrangement;
393 f. Provide for the election of trustees to the board of trustees; and
394 g. Require the trustees to discharge their duties with respect to the trust in accordance with the
395 fiduciary duties defined in ERISA;
396 4. Five or more members shall participate in one or more health benefit plans;
397 5. The trust shall establish and maintain reserves determined in accordance with sound actuarial
398 principles and in compliance with all financial and solvency requirements imposed upon domestic self-
399 funded MEWAs;

400 6. The trust shall purchase and maintain policies of specific, aggregate, and terminal excess
401 insurance with retention levels determined in accordance with sound actuarial principles from insurers
402 licensed to transact the business of insurance in the Commonwealth;
403 7. The trust shall secure one or more guarantees or standby letters of credit that:
404 a. Guarantee the payment of claims under the health benefit plan in an aggregate amount not less
405 than the amount of the trust's annual aggregate excess insurance retention level minus (i) the annual
406 premium assessments for the health benefit plans and (ii) the trust's net assets, which amount shall be the
407 net of the trust's reasonable estimate of incurred but not reported claims; and
408 b. Have been issued by a qualified United States financial institution, as such term is used in
409 subdivision 2 c of § 38.2-1316.4;
410 8. The trust shall purchase and maintain commercially reasonable fiduciary liability insurance;
411 9. The trust shall purchase and maintain a bond that satisfies the requirements of ERISA;
412 10. The trust is audited annually by an independent certified public accountant; and
413 11. The trust does not include in its name the words "insurance," "insurer," "underwriter,"
414 "mutual," or any other word or term or combination of words or terms that is uniquely descriptive of an
415 insurance company or insurance business unless the context of the remaining words or terms clearly
416 indicates that the entity is not an insurance company and is not transacting the business of insurance.
417 **§ 59.1-591. Additional requirements.**
418 A. The board of trustees established pursuant to subsection B of § 59.1-590 shall (i) operate any
419 health benefit plans in accordance with the fiduciary duties defined in ERISA and (ii) have the power to
420 make and collect special assessments against members and, if any assessment is not timely paid, to enforce
421 collection of such assessment.
422 B. Each member shall be liable for his allocated share of the liabilities of the sponsoring association
423 under a health benefit plan as determined by the board of trustees.
424 C. Health benefit plan documents shall have the following statement printed on the first page in
425 size 14-point boldface type:

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

433 **§ 59.1-592. Exemptions; license tax.**

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

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