VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 38.2-1700 and 38.2-3420 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 1 of Title 3.2 an article numbered 4, consisting of sections numbered 3.2-116 through 3.2-119, relating to the formation of benefits consortium by a sponsoring association operating as nonprofit agricultural organization.

[H 1661]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-1700 and 38.2-3420 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 1 of Title 3.2 an article numbered 4, consisting of sections numbered 3.2-116 through 3.2-119, as follows:

Article 4.

Benefits Consortium.

§ 3.2-116. Definitions.

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

"Benefits consortium" means a trust that complies with the conditions set forth in § 3.2-117.

"Benefits plan" means a health plan that is sponsored by a sponsoring association and offered or sold to members through a trust to provide health benefits as permitted under ERISA and the provisions of this chapter.

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

"Health benefits" means coverage for all or a portion of the costs of medical, prescription drug, dental, and vision care incurred by an individual covered by a health plan.

"Health plan" has the meaning ascribed to employee welfare benefit plan in § 3(1) of ERISA at 29 U.S.C. § 1002(1).

"Member" means a person that (i) conducts business operations within the Commonwealth, (ii) employs individuals who reside in the Commonwealth, and (iii) is a member of the sponsoring association.

"Sponsoring association" means a nonstock corporation formed under Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 that:

1. Operates as a nonprofit agricultural organization as domiciled in the Commonwealth and created primarily to promote programs for the development of rural communities and the economic stability and sustainability of farmers in the Commonwealth;

2. Has been actively in existence for at least 10 years;

3. Has had in the five preceding years an average of not fewer than five members;

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

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

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

7. Does not make any benefits plan available to any person who is not a member of the association; 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.

"Trust" means a trust that (i) is established to accept and hold assets of a health 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 benefits plan and (ii) complies with the conditions set forth in § 3.2-117.

§ 3.2-117. Conditions for a benefits consortium.

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

1. The trust is 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 benefits plans offered through the trust as a multiple employer welfare arrangement;

3. The trust operates as a nonprofit voluntary employee beneficiary association within the meaning of § 501(c)(9) of the Internal Revenue Code of 1986;

4. The trust's organizational documents:

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

b. State that its purpose 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 benefits 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 insurance, self-insurance, or a combination thereof, as determined by the trustee, and for defraying reasonable expenses of administering and operating the trust and any benefits plan;

d. Limit participation in benefits plans to the sponsoring association and its members;

e. Limit the health plans offered through the trust to benefits plans;

f. Grant the sponsoring association the power to appoint the trustee of the trust;

g. Provide the trustee with powers for the control and management of the trust; and

h. Require the trustee to discharge its duties with respect to the trust in accordance with the fiduciary duties defined in ERISA;

5. Five or more members participate in one or more benefits plans;

6. The trust establishes and maintains reserves determined in accordance with sound actuarial principles;

7. The trust has purchased and maintains 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;

8. The trust has secured one or more guarantees or standby letters of credit that:

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

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

9. The trust has purchased and maintains commercially reasonable fiduciary liability insurance;

10. The trust has purchased and maintains a bond that satisfies the requirements of ERISA;

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

12. 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 carrying on the business of insurance; and

13. The trust does not pay commissions or other remuneration to any person that is conditioned upon the enrollment of persons in any benefits plan.

§ 3.2-118. Additional requirements.

A. The board of directors of the sponsoring association shall:

1. Have exclusive fiscal control over and responsibility for the operation of any benefits plan;

2. Operate any benefits plans in accordance with the fiduciary duties defined in ERISA; and

3. 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 its allocated share of the liabilities of the sponsoring association under a benefits plan as determined by the board of directors.

§ 3.2-119. Sponsoring association not subject to regulation or taxation as an insurance company.

The sponsoring association of a benefits consortium shall not, by virtue of its sponsorship of the benefits consortium or any benefits plan, be subject to:

1. The provisions of Title 38.2 or regulations adopted thereunder, including those provisions and regulations otherwise applicable to multiple employer welfare arrangements; or

2. The tax levied on insurance companies pursuant to § 58.1-2501.

§ 38.2-1700. Purpose and applicability of chapter.

A. The purpose of this chapter is to protect, subject to certain limitations, the persons specified in

subsection B against failure in the performance of contractual obligations, under life, accident and sickness insurance, and annuity policies, plans, or contracts specified in subsection C because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts. This chapter shall be construed to effect this purpose. To provide this protection, an association of member insurers is created to pay benefits and to continue coverage as limited by this chapter, and members of the Association are subject to assessments to provide funds to carry out the purpose of this chapter.

B. This chapter shall provide coverage for the policies and contracts specified in subsection C as follows:

1. This chapter shall provide coverage, for the policies and contracts specified in subsection C, to persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under accident and sickness insurance policies or certificates, of the persons covered under subdivision B 2.

2. This chapter shall provide coverage, for the policies and contracts specified in subsection C, to persons who are owners of or certificate holders or enrollees under the policies or contracts, other than unallocated annuity contracts and structured settlement annuities, and in each case who:

a. Are residents; or

b. Are not residents and (i) the member insurer that issued the policies or contracts is domiciled in the Commonwealth, (ii) the states in which the persons reside have associations similar to the Association, and (iii) the persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

3. For unallocated annuity contracts specified in subsection C, subdivisions B 1 and B 2 shall not apply, and this chapter, except as provided in subdivisions B 5 and B 6, shall provide coverage to persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in the Commonwealth.

4. For structured settlement annuities specified in subsection C, subdivision B 1 and B 2 shall not apply and this chapter, except as provided in subdivisions B 5 and B 6, shall provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

a. Is a resident, regardless of where the contract owner resides; or

b. Is not a resident and both (i) the contract owner of the structured settlement annuity is (a) a resident or (b) not a resident but the insurer that issued the structured settlement annuity is domiciled in the Commonwealth and the state in which the contract owner resides has an association similar to the Association; and (ii) neither the payee or beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

5. This chapter shall not provide coverage to:

a. A person who is a payee, or beneficiary, of a contract owner resident of the Commonwealth if the payee, or beneficiary, is afforded any coverage by the association of another state; or

b. A person covered under subdivision B 3 if any coverage is provided by the association of another state to the person.

6. This chapter is intended to provide coverage to a person who is a resident of the Commonwealth and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this subdivision in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

C. This chapter shall:

1. Provide coverage to the persons specified in subsection B for policies or contracts of direct, nongroup life insurance, accident and sickness insurance, which for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates, or annuities, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, in each case except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts. This chapter shall apply also to dental benefit contracts entered into with a dental plan organization as provided in Chapter 61 (§ 38.2-6100 et seq.).

2. Except as otherwise provided in subdivision 3, not provide coverage for:

a. A portion of a policy or contract not guaranteed by a member insurer or under which the risk is borne by the policy or contract owner;

b. A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

c. A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(1) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(2) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

d. A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(1) ~~A multiple employer welfare arrangement as defined in 29 U.S.C. § 1144;~~

~~(2)~~ A minimum premium group insurance plan;

~~(3)~~ *(2)* A stop-loss agreement described in subsection B of § 38.2-109; or

~~(4)~~ *(3)* An administrative services only contract;

e. A portion of a policy or contract to the extent that it provides for:

(1) Dividends or experience rating credits;

(2) Voting rights; or

(3) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

f. A policy or contract issued in the Commonwealth by a member insurer at a time when its license to issue the policy or contract in the Commonwealth had been suspended, revoked, not renewed, or voluntarily withdrawn;

g. An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

h. A portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan;

i. A portion of a policy or contract to the extent that the assessments required by § 38.2-1705 with respect to the policy or contract are preempted by federal or state law;

j. An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including:

(1) Claims based on marketing materials;

(2) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(3) Misrepresentations of or regarding policy or contract benefits;

(4) Extra-contractual claims; or

(5) A claim for penalties or consequential or incidental damages;

k. A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

l. A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

m. A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (known as Medicare Parts C and D); Subchapter XIX, Chapter 7 of Title 42 of the United States Code (known as Medicaid); § 32.1-352 (known as FAMIS); or any regulations issued pursuant thereto; or

n. A charitable gift annuity as defined in § 38.2-106.1.

3. The exclusion from coverage referenced in subdivision 2 c shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other accident and sickness insurance benefits. *The exclusion from coverage referenced in subdivision 2 d shall not apply to any portion of a policy or contract issued by a self-funded multiple employer welfare arrangement as set forth in subsection B of § 38.2-3420.*

D. The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:

1. The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

2. With respect to:

a. One life, regardless of the number of policies or contracts:

(1) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(2) For accident and sickness insurance benefits, (i) $100,000 for coverage not defined as disability income insurance, health benefit plans, or long-term care insurance including any net cash surrender and net cash withdrawal values; (ii) $300,000 for disability income insurance and $300,000 for long-term care insurance; and (iii) $500,000 for health benefit plans; and

(3) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

b. Each individual participating in a benefit plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code who (i) selected an investment option that includes investment in unallocated annuity contracts and (ii) is covered by such an unallocated annuity contract, including the beneficiaries of each such individual if deceased, in the aggregate, $250,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values;

c. Each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any; and

d. One plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts part or all of any of which is not included in subdivision 2 b, $5 million in benefits, irrespective of the number of contracts with respect to the plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit or two or more plan sponsors, coverage shall be afforded by the Association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in the Commonwealth and in no event shall the Association be obligated to cover more than $5 million in benefits with respect to all such unallocated contracts.

e. In no event shall the Association be obligated to cover (i) more than an aggregate of $350,000 in benefits with respect to any one life under subdivisions D 2 a, b, and c except with respect to benefits for health benefit plans under subdivision D 2 a (2), in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual, or (ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5 million in benefits, regardless of the number of policies and contracts held by the owner.

f. The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

g. For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which such rider relates.

E. In performing its obligations to provide coverage under § 38.2-1704, the Association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a

covered policy or contract that the Association has determined, with the concurrence of the Commission, do not materially affect the economic values or economic benefits of the covered policy or contract.

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

A. Except as provided in ~~subsection~~ *subsections* B *and 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 ascribed to the term 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.

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. Notwithstanding any other section of this title or Article 4 (§ 3.2-116 et seq.) of Chapter 1 of Title 3.2 to the contrary:

1. Health benefit plans issued by a self-funded MEWA shall be subject to taxes and maintenance assessments levied upon insurance companies pursuant to Chapter 25 (§ 58.1-2500 et seq.) of Title 58.1;

2. Health benefit plans issued by a self-funded MEWA are subject to protections of and other provisions of the Virginia Life, Accident and Sickness Insurance Guaranty Association established under Chapter 17 (§ 38.2-1700 et seq.);

3. 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; and

4. Health benefit plans issued by a self-funded MEWA shall be exempt from all statutory requirements relating to insurance premium rates, policy forms, and policy cancellation and nonrenewal.

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.

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 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 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.