CRC BENEFITS

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VIRGINIA

# Regulatory Compliance and Resources by State

## STATE CONTINUATION OF COVERAGE

An enrollee whose eligibility for coverage terminates under the group contract shall have the opportunity to continue coverage under the existing group contract for a period of at least 12 months immediately following the date of termination of the enrollee's eligibility for coverage under the group contract. Continuation coverage shall not be applicable if the group contract holder is required by federal law to provide for continuation of coverage under its group health plan pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) (P.L. 99-272). Coverage shall be provided without additional evidence of insurability subject to the following requirements:

1. The application and payment for the continued coverage is made to the group contract holder within 31 days after issuance of the written notice required in subsection C of this section, but in no event beyond the 60-day period following the date of the termination of the person's eligibility;
2. Each premium for the continued coverage is timely paid to the group contract holder on a monthly basis during the 12-month period; and
3. The premium for continuing the group coverage shall be at the health care plan's current rate applicable to similarly situated individuals under the group contract plus any applicable administrative fee not to exceed 2.0% of the current rate.

**A continuation of coverage shall not be required to be made available when:**

1. The enrollee is covered by or is eligible for benefits under Title XVIII of the Social Security Act (42 USC § 1395 et seq.) known as Medicare;
2. The enrollee is covered by substantially the same level of benefits under any policy, contract, or plan for individuals in a group;
3. The enrollee has not been continuously covered during the three-month period immediately preceding the enrollee's termination of coverage;
4. The enrollee was terminated by the healthcare plan for any of the reasons stated in 14VAC5-211-230 A 1 or 2, or coverage was rescinded; or
5. The enrollee was terminated from a plan administered by the Department of Medical Assistance Services that provided benefits pursuant to Title XIX or XXI of the Social Security Act (42 USC § 1396 et seq. or § 1397aa et seq.). The group contract holder shall provide each enrollee or other person covered under the group contract written notice of the procedures and timeframes for obtaining continuation of coverage under the group contract. The notice shall be provided within 14 days of the group contract holder's knowledge of the enrollee's or other covered person's loss of eligibility under the group contract.

## PAID FAMILY LEAVE

Coverage Options: Voluntary fully insured paid family leave benefits available for insurance carriers to offer as a rider to a short-term disability policy, included in a short-term disability policy, or as a standalone policy. While there are advantages to the voluntary nature of the law, Virginia's policy provides no guarantee that employers will utilize the insurance to offer a paid leave benefit to their employees. Additionally, the law does not establish minimum standards for benefit size, maximum duration, or other characteristics that influence benefit quality.





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**Benefits:** The insurance codes do not establish minimum standards for family leave insurance other than the following absence reasons.

**Absence reasons:** Family leave insurance may replace all or part of an employee's income loss due to the following events:

- Birth of a child or adoption of a child by the employee
- Placement of a child with the employee for foster care
- Care of a family member of the employee who has a serious health condition
- Circumstances arising out of the fact that the employee's family member who is a service member is on active duty or has been notified of an impending call or order to active duty

**Contributions:** Voluntary offering. No mandatory payroll contributions to support a state program.

## STATE EMPLOYER REPORTING/NA

## PAID SICK LEAVE

Virginia does not have a universal unpaid sick leave policy for private-sector employers.

## MANDATORY 401K

Participation is mandatory for businesses who:

- Have been in operation for at least two years
- Had 25 or more employees in the previous calendar year
- Do not already offer a qualified retirement plan to employees

A qualified retirement plan includes a 401(a), 401(k), 403(a), 403(b), 408(k), 408(p), or 457(b).

The law also stipulates that employers eligible to participate includes self-employed individuals, sole proprietors, non-governmental businesses or other enterprises, whether for-profit or not-for-profit.

Employers will automatically enroll eligible employees — anyone at least 18 years of age who is employed at least 30 hours per week and receives wages in Virginia — but employees can opt out. Part-time employees (those who work fewer than 30 hours a week) are not eligible after the Virginia Senate defeated an amendment by Gov. Northam to include part-timers in the program.

There is a default contribution amount of 5% per pay period with an annual auto-escalation of 1%, up to a maximum of 10%.

Employers cannot contribute to the program such as matching funds. Register by the deadline (when provided) or offer a qualified option that satisfies the mandate.

Set up payroll deduction for employees (the percentage of wages allocated per pay period has yet to be determined).

Hold an annual open enrollment period.

There is a penalty of $200 per employee annually for non-compliance.

## SURPRISE BILLING

Virginia's new balance billing law and rules, effective January 1, 2021, protects consumers from getting billed by an out-of-network healthcare provider for emergency services at a hospital or for certain non-emergency services during a scheduled procedure at an in-network hospital or other healthcare facility. The law covers emergency services, laboratory services, and any professional non-emergency services, including:

- Surgery
- Anesthesia
- Pathology
- Radiology
- Hospitalist services

If a consumer is treated by an out-of-network provider or facility for services covered by the new law, the provider or facility will submit the claim to the consumer's insurer. They will be paid a "commercially reasonable amount" which is based on payments for the same or similar services in a similar geographic area. The insurer and facility or provider must first try to agree on this amount.

**What should I do if I get a surprise medical bill?**

Effective January 1, 2021, you cannot be balance billed or surprise billed for certain services.

Contact the provider or facility and tell them you believe you've been wrongly billed. Request that your bill be lowered. After contacting the medical provider, you can also contact your insurance company for assistance. Reference your policy or member ID card for your insurance company's contact information. If you are still unsatisfied after contacting the medical provider and your insurance company, you can also

file a complaint with our office and we will review your case. If the medical provider and your insurer are unable to agree on an acceptable payment, the provider and the insurer can then enter arbitration.

Arbitration will only affect what you will pay if you are covered by a catastrophic or high deductible health plan with a Health Savings Account (HSA) and have not reached your full deductible amount.

**The Virginia surprise balance billing law applies to:**

- All Virginia-regulated managed care plans
- Plans bought through HealthCare.gov
- State employee health benefit plans
- Self-funded group health plans not regulated by Virginia and certain other self-funded group health plans mentioned in the balance billing law may opt-in to offer the balance billing protections to their enrollees.

**List of Elective Group Health Plans Opted-In to Balance Billing**

If your plan is not on the list, you should check your plan documents or contact your health plan for information on whether this law applies to your health plan.

**How much must I pay for a surprise medical bill?**

You are not responsible for paying a surprise medical bill if the protections apply. Your insurer must pay the out-of-network provider and facility directly.

You are only responsible to pay for what you would normally pay for the same service from an in-network provider, including any copays, coinsurance and deductible.

**What health insurers must do:**

Base your financial responsibility on what you would pay an in-network provider or in-network facility in your area and show the amount on your Explanation of Benefits (EOB).

**Exception:** if you have a high deductible health plan with a Health Savings Account (HSA) or a catastrophic health plan, you may need to pay additional costs, but you still will not be responsible for more than your cost share.

- Include any amount you pay for emergency services or certain out-of-network services at an in-network facility toward your in-network deductible and out-of-pocket limit.
- Provide the names of providers, hospitals, and facilities that are in-network.
- Provide notice to you of your rights (in English, Spanish, Korean, or Vietnamese) under the balance billing law and let you know when you can and cannot be balance billed.

**What medical providers and facilities must do**

- Tell you which provider networks they participate in
- Refund any amount you overpay within 30 business days
- Provide notice to you of your rights (in English, Spanish, Korean, or Vietnamese) under the balance billing law to let you know when you can and cannot be balance billed
- Not ask you to limit or give up these rights

## RESOURCES

https://www.scc.virginia.gov/pages/Bureau-of-Insurance