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HOUSE BILL NO. 2024

Offered January 14, 2009

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A BILL to amend and reenact §§ 32.1-102.4 and 38.2-4214 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 38.2-3406.1 and 38.2-3406.2, relating to increasing the availability of basic health insurance coverage in the Commonwealth.

Patrons—Marshall, D.W., Athey, Crockett-Stark, Frederick, Hamilton, Hugo, Kilgore, Landes, Lingamfelter, Merricks, Miller, J.H., Nixon, Nutter, Poindexter, Rust, Saxman, Scott, E.T. and Sherwood

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-102.4 and 38.2-4214 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.2-3406.1 and 38.2-3406.2 as follows:

§ 32.1-102.4. Conditions of certificates; monitoring; revocation of certificates.

A. A certificate shall be issued with a schedule for the completion of the project and a maximum capital expenditure amount for the project. The schedule may not be extended and the maximum capital expenditure may not be exceeded without the approval of the Commissioner in accordance with the regulations of the Board.

B. The Commissioner shall monitor each project for which a certificate is issued to determine its progress and compliance with the schedule and with the maximum capital expenditure. The Commissioner shall also monitor all continuing care retirement communities for which a certificate is issued authorizing the establishment of a nursing home facility or an increase in the number of nursing home beds pursuant to § 32.1-102.3:2 and shall enforce compliance with the conditions for such applications which are required by § 32.1-102.3:2. Any willful violation of a provision of § 32.1-102.3:2 or conditions of a certificate of public need granted under the provisions of § 32.1-102.3:2 shall be subject to a civil penalty of up to $100 per violation per day until the date the Commissioner determines that such facility is in compliance.

C. A certificate may be revoked when:

1. Substantial and continuing progress towards completion of the project in accordance with the schedule has not been made;

2. The maximum capital expenditure amount set for the project is exceeded;

3. The applicant has willfully or recklessly misrepresented intentions or facts in obtaining a certificate; or

4. A continuing care retirement community applicant has failed to honor the conditions of a certificate allowing the establishment of a nursing home facility or granting an increase in the number of nursing home beds in an existing facility which was approved in accordance with the requirements of § 32.1-102.3:2.

D. Further, the Commissioner shall not approve an extension for a schedule for completion of any project or the exceeding of the maximum capital expenditure of any project unless such extension or excess complies with the limitations provided in the regulations promulgated by the Board pursuant to § 32.1-102.2.

E. Any person willfully violating the Board's regulations establishing limitations for schedules for completion of any project or limitations on the exceeding of the maximum capital expenditure of any project shall be subject to a civil penalty of up to $100 per violation per day until the date of completion of the project.

F. The Commissioner may condition, pursuant to the regulations of the Board, the approval of a certificate (i) upon the agreement of the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care or (ii) upon the agreement of the applicant to facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area, *which conditions are herein referred to as "charity care conditions."*

If the approval of a certificate is conditioned upon an agreement containing charity care conditions and the person to whom a certificate is issued fails to honor such agreement, the person shall file with the Department a plan of correction that identifies how the person will meet its charity care conditions and provides a timeframe for the person's satisfaction of its charity care conditions, which plan if

approved by the Department shall be binding upon the person as an amendment to the agreement upon which approval of the certificate was conditioned. A plan of correction may provide that a person may satisfy a charity care condition by making direct payments to (a) an entity that is authorized, pursuant to a memorandum of understanding with the Department, to receive payments satisfying charity care conditions or (b) a private nonprofit foundation that funds basic health insurance coverage to indigents pursuant to a memorandum of understanding with the Department that authorizes it to receive contributions satisfying charity care conditions. The person filing the plan of correction shall provide to the Department, upon request, documentation demonstrating that the person is in compliance with the provisions of the plan of correction and is satisfying its charity care conditions.

Any person willfully refusing, failing, or neglecting to honor such agreement shall be subject to a civil penalty of up to $100 per violation per day until the date of compliance.

G. For the purposes of this section, "completion" means conclusion of construction activities necessary for the substantial performance of the contract.

§ 38.2-3406.1. Application of requirements that policies offered by qualified small employers include state-mandated health benefits.

A. As used in this section:

"Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under a group policy of accident and sickness insurance, hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, which coverage is subject to this title or is provided under a plan regulated under the Employee Retirement Income Security Act of 1974.

"Health insurer" means any insurance company that issues accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis or a corporation that provides accident and sickness subscription contracts, that is licensed to engage in such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514 (b) (2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b) (2)).

"Qualified small employer" means a small employer that has not offered health insurance coverage to its employees during the six months prior to the date a policy under this section becomes effective.

"Small employer" means, with respect to a calendar year and a plan year, an employer located in the Commonwealth that employed at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the date a policy under this section becomes effective.

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16, 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, or § 38.2-4221. For purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

B. Notwithstanding any provision of this title to the contrary, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, and a group accident and sickness subscription contract, that is offered, sold, or issued by a health insurer to a qualified small employer:

1. Shall not be required to include coverage, or the offer of coverage, for any state-mandated health benefit; and

2. May include any, or none, of the state-mandated health benefits as the health insurer and the qualified small employer shall agree.

C. A health insurer offering an insurance policy or subscription contract to a qualified small employer shall inform the employer that a policy or contract is not required to provide state-mandated health benefits.

D. A health insurer selling or issuing an insurance policy or subscription contract to a qualified small employer that does not include all state-mandated health benefits shall provide to the qualified small employer and to each participant a written disclosure statement that lists any state-mandated health benefits that the policy or subscription contract does not provide.

E. The Commission shall adopt any regulations necessary to implement this section.

§ 38.2-3406.2. Capped benefits under insurance policies and contracts.

Nothing in this chapter or Chapters 35 (§ 38.2-3500 et seq.) or 42 (§ 38.2-4200 et seq.) shall prohibit the offering, sale, or issuance of accident and sickness insurance policies or subscription contracts that cap or limit the total annual or lifetime benefits provided under an accident and sickness insurance policy or subscription contracts at specified dollar amounts.

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

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, *38.2-3406.1, 38.2-3406.2,* 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall apply to the operation of a plan.

2. That the provisions of § 38.2-3406.2 of the Code of Virginia are declarative of existing law.