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HOUSE BILL NO. 2024

AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Commerce and Labor
on February 5, 2009)

(Patrons Prior to Substitute—Delegates Marshall, D.W. and Frederick [HB 2209])

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.

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.

If a certificate is conditioned pursuant to this subsection, and the certificate holder fails to satisfy the conditions of the certificate, the certificate holder shall file a plan of correction with the Department for approval. The plan of correction shall identify how the certificate holder shall satisfy the conditions of the certificate and provide a time frame for satisfaction of the conditions of the certificate. A certificate holder may, pursuant to an approved plan of correction, satisfy conditions of a certificate by (i) making direct payments to an organization authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, or (ii) making direct payments to a private nonprofit foundation that funds basic insurance coverage for indigents authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate. The certificate holder shall provide documentation to the Department demonstrating that the

60 certificate holder has satisfied the conditions of the certificate as set forth in the approved plan of
61 correction.

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

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

66 § 38.2-3406.1. Application of requirements that policies offered by small employers include
67 state-mandated health benefits.

68 A. As used in this section:

69 "Eligible individual" means an individual who is uninsured, is employed by a small employer, and
70 has satisfied applicable waiting period requirements.

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

77 "Health insurer" means any insurance company that issues accident and sickness insurance policies
78 providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis or a
79 corporation that provides accident and sickness subscription contracts, that is licensed to engage in
80 such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate
81 insurance within the meaning of § 514 (b) (2) of the Employee Retirement Income Security Act of 1974
82 (29 U.S.C. § 1144 (b) (2)).

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

87 "State-mandated health benefit" means coverage required under this title or other laws of the
88 Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a
89 health-related condition that (i) includes coverage for specific health care services or benefits; (ii)
90 places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime
91 maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from
92 whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation,
93 any coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through
94 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,
95 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, or § 38.2-4221. For
96 purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by
97 federal law.

98 "Uninsured individual" means an individual who does not have, is not eligible for, and has not had
99 at any time within the six months preceding the date of application for coverage under a policy
100 authorized by this section, either in his individual capacity or as a dependent of another person,
101 coverage under any of the following:

- 102 1. A group health plan;
- 103 2. Health insurance coverage;
- 104 3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);
- 105 4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting
106 solely of benefits under section 1928;
- 107 5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);
- 108 6. A medical care program of the Indian Health Service or of a tribal organization;
- 109 7. A federal employee health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C.
110 § 8901 et seq.);
- 111 8. A public health plan, as defined in federal regulations; or
- 112 9. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

113 In addition, "uninsured individual" includes any individual who does not have individual health
114 insurance coverage on, and has not had individual health insurance coverage at any time within the six
115 months preceding, the date of application for a policy written pursuant to this section.

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

- 121 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 small employer shall agree.

Notwithstanding any provision of this section to the contrary, if any plan authorized by this section includes and offers health care services covered by the plan that may be legally rendered by a health care provider listed in § 38.2-3408, that plan shall allow for the reimbursement of such covered services when rendered by such provider. Unless otherwise provided in this section, this provision shall not require any benefit be provided as a covered service.

C. A health insurer offering an insurance policy or subscription contract to a 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 small employer that does not include all state-mandated health benefits shall provide to the 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.

3. That health insurers offering plans pursuant to § 38.2-3406.1 of the Code of Virginia shall report annually to the Bureau of Insurance on the number of small employers and individuals using plans that do not offer mandated benefits, the coverage provided, and the cost of premiums and out-of-pocket expenses. The Bureau of Insurance shall compile this information and evaluate the impact of such plans in a report to be submitted to the Governor and General Assembly on August 1, 2010, and August 1, 2011.