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HOUSE BILL NO. 1953

Offered January 10, 2007

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A BILL to amend and reenact §§ 6.1-5, 32.1-325, 54.1-2820, and 54.1-2822 of the Code of Virginia, relating to arrangements for payment of burial and funeral expenses.

Patron—Morgan

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 6.1-5, 32.1-325, 54.1-2820, and 54.1-2822 of the Code of Virginia are amended and reenacted as follows:

§ 6.1-5. Who shall not do a banking or trust business.

No person, copartnership or corporation, except corporations duly chartered and already conducting the banking business or trust business in this Commonwealth under authority of the laws of this Commonwealth or the United States, or which shall hereafter be incorporated under the laws of this Commonwealth or authorized to do business in this Commonwealth under the banking laws of the United States, and except banks which may be authorized, after July 1, 1995, to establish and operate one or more branches in this Commonwealth under Article 5.1 (§ 6.1-44.1 et seq.) or 5.2 (§ 6.1-44.15 et seq.) of this chapter, and except trust companies or institutions that may be authorized to establish and operate one or more trust offices or conduct business in this Commonwealth under Article 3.1 (§ 6.1-32.1 et seq.), Article 3.2 (§ 6.1-32.11 et seq.), Article 3.2:1 (§ 6.1-32.30:1 et seq.) or Article 3.3 (§ 6.1-32.31 et seq.) of this chapter, shall engage in the banking business or trust business in this Commonwealth, and no foreign corporation, except as permitted in Chapter 14 (§ 6.1-390 et seq.) and Chapter 15 (§ 6.1-398 et seq.) of this title, shall do a banking or trust business in this Commonwealth. Nothing in this chapter, however, shall:

~~(~~1~~)~~. Prevent a natural person from qualifying and acting as trustee, personal representative, guardian, conservator, committee or in any other fiduciary capacity,

~~(~~2~~)~~. Prevent any person or copartnership or corporation from lending money on real estate and personal security or collateral, or from guaranteeing the payment of bonds, notes, bills and other obligations, or from purchasing or selling stocks and bonds, ~~or~~

~~(~~3~~)~~. Prevent any bank or trust company organized under the laws of this Commonwealth from qualifying and acting in another state or in the District of Columbia, as trustee, personal representative, guardian of a minor, conservator or committee or in any other fiduciary capacity, when permitted so to do by the laws of such other state or District*; or*

4. Prevent an incorporated association that is authorized to sell burial association group life insurance certificates in the Commonwealth, as described in the definition of limited burial insurance authority in § 38.2-1800, whose principal purpose is to assist its members in (i) financial planning for their funerals and burials and (ii) obtaining insurance for the payment, in whole or in part, for funeral, burial, and related expenses, from serving as trustee of a trust established pursuant to § 54.1-2822.

Nothing in this section shall be construed to prevent banks or trust companies organized in this Commonwealth and chartered under the laws of the United States from transacting business in Virginia.

Nothing in this section shall be construed to prevent a real estate broker as defined in § 54.1-2100 from owning or operating a bank provided that the requirements of this chapter are met.

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of ~~$3,500~~ *$7,000* for the individual and an amount not in excess of ~~$3,500~~ *$7,000* for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the

face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician, physician assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal

examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;

22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women;

23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for both programs; and

24. A provision, when authorized by and in compliance with federal law, to establish a public-private long-term care partnership program between the Commonwealth of Virginia and private insurance companies that shall be established through the filing of an amendment to the state plan for medical assistance services by the Department of Medical Assistance Services. The purpose of the program shall be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for such services through encouraging the purchase of private long-term care insurance policies that have been designated as qualified state long-term care insurance partnerships and may be used as the first

source of benefits for the participant's long-term care. Components of the program, including the treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and applicable federal guidelines.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider who has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a marriage and family therapist, clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed

to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of 18 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 54.1-2820. Requirements of preneed funeral contracts.

A. It shall be unlawful for any person residing or doing business within this Commonwealth, to make, either directly or indirectly by any means, a preneed funeral contract unless the contract:

1. Is made on forms prescribed by the Board and is written in clear, understandable language and printed in easy-to-read type, size and style;

2. Identifies the seller, seller's license number and contract buyer and the person for whom the contract is purchased if other than the contract buyer;

3. Contains a complete description of the supplies or services purchased;

4. Clearly discloses whether the price of the supplies and services purchased is guaranteed;

5. States if funds are required to be trusted pursuant to § 54.1-2822, the amount to be trusted, the name of the trustee, the disposition of the interest, the fees, expenses and taxes which may be deducted from the interest and a statement of the buyer's responsibility for taxes owed on the interest;

6. Contains the name, address and telephone number of the Board and lists the Board as the regulatory agency which handles consumer complaints;

7. Provides that any person who makes payment under the contract may terminate the agreement at any time prior to the furnishing of the services or supplies contracted for except as provided pursuant to subsection B; if the purchaser terminates the contract within 30 days of execution, the purchaser shall be refunded all consideration paid or delivered, together with any interest or income accrued thereon; if the purchaser terminates the contract after 30 days, the purchaser shall be refunded any amounts required to be deposited under § 54.1-2822, together with any interest or income accrued thereon;

8. Provides that if the particular supplies and services specified in the contract are unavailable at the time of delivery, the seller shall be required to furnish supplies and services similar in style and at least equal in quality of material and workmanship and the representative of the deceased shall have the right to choose the supplies or services to be substituted;

9. Discloses any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or prearrangement guarantee; and

10. Complies with all disclosure requirements imposed by the Board.

If the contract seller will not be furnishing the supplies and services to the purchaser, the contract

seller must attach to the preneed funeral contract a copy of the seller's agreement with the provider.

B. Subject to the requirements of § 54.1-2822, a preneed funeral contract may provide for an irrevocable trust or an amount in an irrevocable trust that is specifically identified as available exclusively for funeral or burial expenses, where:

1. A person irrevocably contracts for funeral goods and services, such person funds the contract by prepaying for the goods and services, and the funeral provider residing or doing business within the Commonwealth subsequently places the funds in a trust; or

2. A person establishes an irrevocable trust naming the funeral provider as the beneficiary; however, such person shall have the right to change the beneficiary to another funeral provider pursuant to § 54.1-2822.

C. If a life insurance or annuity contract is used to fund the preneed funeral contract, the life insurance or annuity contract shall provide either that the face value thereof shall be adjusted annually by a factor equal to the *annualized* Consumer Price Index as published by the ~~Office of Management and Budget of the United States~~ *Bureau of Labor Statistics of the United States Department of Labor*, or a benefit payable at death under such contract that will equal or exceed the sum of all premiums paid for such contract plus interest or dividends, which for the first 15 years shall be compounded annually at a rate of at least five percent. In any event, interest or dividends shall continue to be paid after 15 years. In addition, the following must also be disclosed as prescribed by the Board:

1. The fact that a life insurance policy or annuity contract is involved or being used to fund the preneed contract;

2. The nature of the relationship among the soliciting agent, the provider of the supplies or services, the prearranger and the insurer;

3. The relationship of the life insurance policy or annuity contract to the funding of the preneed contract and the nature and existence of any guarantees relating to the preneed contract; and

4. The impact on the preneed contract of (i) any changes in the life insurance policy or annuity contract including but not limited to changes in the assignment, beneficiary designation or use of the proceeds, (ii) any penalties to be incurred by the policyholder as a result of failure to make premium payments, (iii) any penalties to be incurred or moneys to be received as a result of cancellation or surrender of the life insurance policy or annuity contract, and (iv) all relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy or annuity contract and the amount actually needed to fund the preneed contract.

D. When the consideration consists in whole or in part of any real estate, the contract shall be recorded as an attachment to the deed whereby such real estate is conveyed, and the deed shall be recorded in the clerk's office of the circuit court of the city or county in which the real estate being conveyed is located.

E. If any funeral supplies are sold and delivered prior to the death of the subject for whom they are provided, and the seller or any legal entity in which he or a member of his family has an interest thereafter stores these supplies, the risk of loss or damage shall be upon the seller during such period of storage.

§ 54.1-2822. Deposit of money received pursuant to preneed funeral contract.

A. Within thirty days following the receipt of any money paid pursuant to any preneed funeral contract or interest or income accrued thereon, unless such amounts are paid to fund either an annuity or an insurance policy which will be used to purchase the funeral supplies or services contracted for, the person receiving such amounts shall deposit all consideration paid pursuant to the terms of a preneed funeral contract in which the price of the supplies and services is not guaranteed, or ninety percent of all consideration paid pursuant to the terms of a preneed funeral contract in which the price of the supplies and services is guaranteed, in a special account in a bank or savings institution doing business in this Commonwealth.

B. The funds shall be deposited in separate, identifiable trust accounts setting forth the names of the depositor, the trustee for the person who is the subject of the contract, the name of the person who will render the funeral services and the name of the person who is the subject of the contract. The purchaser shall have the right to change the beneficiary and trustee of the trust at any time prior to the furnishing of the services or supplies contracted for under the preneed funeral contract. Trust account records shall be subject to examination by the Board.

C. No funeral director, embalmer, funeral service licensee, owner of a funeral establishment, or any person employed by or having an interest in a funeral establishment shall serve as trustee of a trust account for which any such person, or any funeral establishment owned by or employing such person or in which such person has an interest, has been named the beneficiary or designated the provider of services, unless two or more such persons are named and serve as trustees and are required to act jointly in such fiduciary capacity. *Subject to the terms of this subsection, and notwithstanding any other provision of law, the trustee for any such trust account may be an incorporated association that is*

authorized to sell burial association group life insurance certificates in the Commonwealth, as described in the definition of limited burial insurance authority in § 38.2-1800, whose principal purpose is to assist its members in (i) financial planning for their funerals and burials and (ii) obtaining insurance for the payment, in whole or in part, for funeral, burial, and related expenses.