098048333

SENATE BILL NO. 976

Offered January 14, 2009

Prefiled January 12, 2009

A BILL to amend the Code of Virginia by adding in Chapter 34 of Title 38.2 an article numbered 6, consisting of sections numbered 38.2-3438 through 38.2-3444, relating to basic health benefit plans.

Patron—Stuart

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 34 of Title 38.2 an article numbered 6, consisting of sections numbered 38.2-3438 through 38.2-3444 as follows:

Article 6.

Basic Health Benefit Plans.

§ 38.2-3438. Definitions.

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

"Basic health benefit plan" means a health benefit plan that provides basic health insurance coverage for eligible individuals and their dependents in compliance with the provisions of this article.

"Basic health insurance coverage" means coverage that provides benefits of at least 75 percent of necessary, reasonable, and customary charges for medical care, including hospitalization, surgery, physician services, emergency services, diagnostic tests, with a minimum annual deductible of $5,000 for the eligible individual and $10,000 for the eligible individual and dependent coverage, with maximum annual amount out-of-pocket limits for co-payments, co-insurance, deductibles, and other cost-sharing arrangement of $10,000 for the eligible individual and $20,000 for the eligible individual and dependents, and with maximum lifetime benefits of at least $1 million, and does not provide benefits for routine physician visits, prescription drugs, or dental treatment, or for any mandated benefit.

"Basic health insurance policy" means an individual health insurance policy, contract, or plan that provides basic health insurance coverage pursuant to the provisions of this article.

"Eligible individual" means an individual who (i) is a resident of the Commonwealth; (ii) has a family income that is at or below 150 percent of the federal poverty level; (iii) has not been insured or had an offer to be insured within six months prior to enrollment in a basic health benefit plan; (iv) is ineligible for full-benefit medical assistance pursuant to Title XIX of the Social Security Act, as amended, or benefits pursuant to Title XXI of the Social Security Act, as amended; and (v) is ineligible for coverage issued pursuant to Title XVIII of the Social Security Act, as amended, or under 10 U.S.C. § 1071 (TriCare/CHAMPUS), as amended.

"Federal poverty level" means the poverty level promulgated and periodically updated by the U.S. Department of Health and Human Services in the Federal Register, under the authority of 42 U.S.C. 9902(2).

"Health benefit plan" means an accident and health insurance policy or certificate, health services plan contract, or health maintenance organization subscriber contract. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance issuer" means an insurer proposing to issue accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, a corporation providing accident and sickness subscription contracts, or a health maintenance organization providing health care plans for health care services.

"Health maintenance organization" has the same meaning as provided in § 38.2-3431.

"Insurer" means an insurance company or health services plan licensed in the Commonwealth to write accident and sickness insurance.

"Mandated benefit" means a coverage or 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.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

§ 38.2-3439. Requirement to offer basic health benefit plans.

Every health insurance issuer shall, as a condition of transacting business in Virginia, offer to eligible individuals a basic health benefit plan in a manner that complies with the provisions of this article.

§ 38.2-3440. Basic health insurance policies.

Each basic health insurance policy shall satisfy all requirements of this article, including the following:

1. The policy may include cost containment and cost-sharing features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians, and other health care providers, subject to the limitations set forth in § 38.2-3407; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; co-payment, co-insurance, deductible or other cost-sharing arrangement as those terms are defined in § 38.2-3407.12; or other managed care provisions; and

2. All insurers shall use a policy form approved by the Commission. An insurer shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. The Commission at any time may, after providing notice and an opportunity for a hearing to an insurer, disapprove the continued use by the insurer of a policy on the grounds that such policy does not meet the requirements of this article.

§ 38.2-3441. Market conduct.

In order to ensure the broadest availability of basic health insurance policies, the Commission shall set market conduct and other requirements for health insurance issuers and agents, including requirements relating to the following:

1. Publication of a list of all insurers who offer basic health insurance policies;

2. The availability of a broadly publicized toll-free telephone number for the Bureau of Insurance for access to information concerning basic health insurance policies; and

3. Periodic reports by health insurance issuers offering basic health insurance policies, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of basic health insurance polices in various categories marketed or issued.

§ 38.2-3442. Limitation on preexisting condition exclusion period.

A health insurance issuer offering basic health insurance policies may impose a preexisting condition limitation only if, and to the extent, permitted under regulations adopted by the Commission in order to ensure that basic health insurance policies comply with requirements of federal law.

§ 38.2-3443. Disclosure of information.

A. Any issuer of basic health insurance policies shall make a reasonable disclosure of the availability of information to eligible individuals, as part of its solicitation and sales materials.

B. An issuer of basic health insurance policies is not required under this article to disclose any information that is proprietary or is a trade secret.

§ 38.2-3444. Applicability of other law.

Except as provided in this article, the terms, conditions, and requirements that are applicable to individual accident and sickness insurance policies pursuant to this title shall apply to basic health insurance policies.