1997 ANNUAL REPORT OF

THE JOINT COMMISSION ON HEALTH CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 45

COMMONWEALTH OF VIRGINIA
RICHMOND
1998

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

June 1, 1998

Senator Stanley C. Walker
Chairman

Jane Norwood Kusiak
Executive Director

Suite 115
Old City Hall
1001 East Broad Street
Richmond, Virginia 23219
(804) 786-5445
Fax (804) 786-5538

TO: The Honorable James S. Gilmore, III, Governor of Virginia
and Members of the General Assembly

Pursuant to the provisions of the Code of Virginia (Title 9, Chapter 38, §§9-311 through 9-316) establishing the Joint Commission on Health Care and setting forth its purpose, we have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 1997.

This 1997 annual report includes a summary of the Joint Commission's 1997 activities and legislative recommendations to the 1998 General Assembly, a report on "point-of-service" health plans, and an overview of health care issues facing Virginia and the nation. Copies of the legislation sponsored by the Joint Commission and passed by the 1998 General Assembly also are included.

In addition to this annual report, a separate report was published as a House or Senate document for each study the Joint Commission conducted pursuant to a joint study resolution. The document numbers of the individual study reports we published are identified on page 5 of this document.

Sincerely,

Stanley C. Walker
Chairman

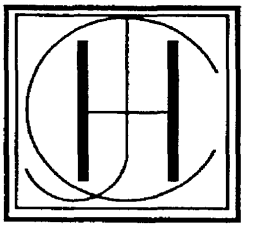
Jane Norwood Kusiak
Executive Director

JOINT COMMISSION ON HEALTH CARE

Chairman
The Honorable Stanley C. Walker
Vice Chairman
The Honorable Kenneth R. Melvin

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Edward L. Schrock
The Honorable Jane H. Woods
The Honorable Thomas G. Baker, Jr.
The Honorable David G. Brickley
The Honorable Julia A. Connally
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable George H. Heilig, Jr.
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Robert C. Metcalf



JOINT COMMISSION ON HEALTH CARE

Staff

Director
Jane Norwood Kusiak

Senior Health Policy Analysts
Patrick W. Finnerty
William L. Murray, Ph.D.

Legislative Health Policy Analyst
Patricia A. Randall

Office Manager
Mamie V. White

Access to the Internet

The Joint Commission's home page on the Internet is located at:
http://legis.state.va.us/jchc/jchchome.htm

Acknowledgements

The Joint Commission extends its sincere appreciation to the Office of the Clerk of the Senate, the Office of the Clerk of the House of Delegates, the Division of Legislative Services, and the Division of Legislative Automated Systems for their assistance and support throughout 1997.

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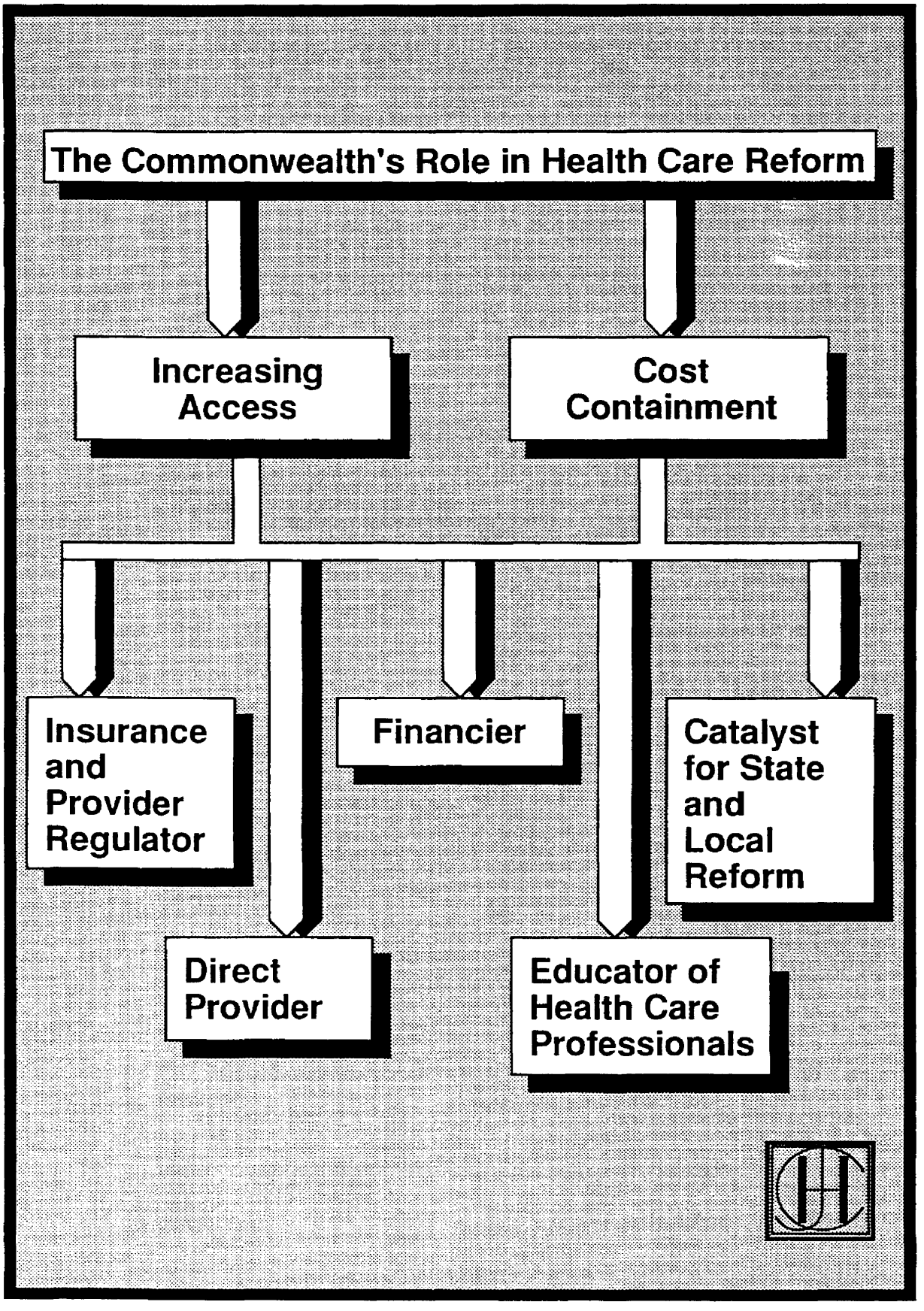
The Commonwealth's Role in Health Care Reform
Increasing Access
Cost Containment
Insurance and Provider Regulator
Financier
Catalyst for State and Local Reform
Direct Provider
Educator of Health Care Professionals

I. SUMMARY OF 1997 ACTIVITIES AND RELATED 1998 GENERAL ASSEMBLY ACTIONS

AUTHORITY FOR STUDY

The Joint Commission on Health Care was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032. This sixteen-member legislative commission, with a separately staffed agency, continues the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session).

1997 JOINT COMMISSION ACTIVITIES

The Joint Commission held seven meetings in 1997, as well as one additional meeting in January, 1998, prior to the 1998 Session of the General Assembly. All meetings were held in the General Assembly Building in Richmond. In addition to the agenda items identified below, monthly staff reports were presented at each meeting.

May 6th Meeting

At the May 6th meeting, staff presented the status of the Joint Commission's 1997 legislation, an overview of the 1997 workplan, and an overview of the workplan for its study on issues relating to the indigent/uninsured. In addition, Joseph M. Teefey, Director, Department of Medical Assistance Services reported on the status of the contract for a Medicaid claims payment system. Deborah D. Oswalt, Executive Director of the Virginia Health Care Foundation presented an overview of the results of the 1996 Survey on the Insurance Status of Virginians. Lastly, Randolph L. Gordon, MD, MPH, Commissioner, Virginia Department of Health, provided a status report on the Department of Health's study on quality of care oversight pursuant to House Bill 2785 of the 1997 Session of the General Assembly.

June 3rd Meeting

At the June 3rd meeting, Chairman Walker announced member appointments to three Subcommittees to focus on the Commission's major

studies: Indigent/Uninsured, Long-Term Care And Aging, and "Point-of-Service."

During the June 3rd meeting, staff presented: (i) the first of three reports on its study of the indigent/uninsured, (ii) the workplan for the Commission's study on long-term care and aging issues, and (iii) the 1997 Annual Report. Bette H. Dillehay, State Data Administrator, Council on Information Management, briefed the Commission on two reports regarding telemedicine issues.

July 2nd Meeting

At the July 2nd meeting, staff presented two issue briefs: the Phase II report on the indigent/uninsured study and an interim report on the "point-of-service" study. In addition, a summary of public comments on the initial phase of the indigent/uninsured study was presented. Randolph L. Gordon, MD, MPH, Commissioner of Health, also presented an interim report on the Department of Health's Study on Quality of Care Oversight (HB 2785).

August 5th Meeting

The August 5th meeting included a summary of public comments on the second phase of the study on the indigent and uninsured, as well as the final report (Phase III) on this study. Staff presented the first of three reports on the long-term care/aging study. Joseph M. Teefey, Director, Department of Medical Assistance Services, provided a preliminary assessment of the 1997 Federal Balanced Budget Act and its impact on Virginia's Medicaid Program. Jeanette Lancaster, Ph.D., RN, FAAN (Chair of the Statewide AHEC Board and Dean of the School of Nursing, University of Virginia) reported on the status of the Area Health Education Centers (AHEC) program.

October 6th Meeting

The October 6th meeting began with an update on the activities of the three subcommittees: Indigent/Uninsured, Long-Term Care, and Point-of-Service. The final phase of the long-term care study was presented, including the study on continuing care retirement communities (CCRCs) that was conducted pursuant to SB1139.

Robert A. Nebiker, Senior Deputy Director, Department of Health Professions, addressed the Commission on issues relating to the transfer of ownership of pharmacies. Paul E, Parker, Director of the Division of Certificate of Public Need, Virginia Department of Health, presented the

Commissioner of Health's annual report on the COPN program. Lastly, Dr. David H. Finifter and Paulette Parker of the Center for Public Policy Research at the College of William & Mary presented the Secretary of Health and Human Resources' study of health-related boards, commissions, and councils conducted pursuant to SJR 317.

November 12th Meeting

During the November 12th meeting, a summary of public comments on the long-term care study (including the CCRC study), and the indigent/uninsured and "point-of-service" studies was presented to the Commission. The staff also updated the members on several health insurance issues, including the following: (i) discussion of potential group accident and sickness insurance statute changes; (ii) revision of the Kassebaum/Kennedy legislation; (iii) a study of pre-existing conditions and community rating pursuant to SB 1181; and (iv) a study of high risk insurance pools pursuant to SJR 337.

Leah Barron, Director of the Louisiana Health Insurance Association, presented an overview of Louisiana's High Risk Pool and her state's experience with high risk pools. Victoria Savoy, CPA, Chief Financial Auditor of the Bureau of Insurance reported on the Bureau's study on managed care regulation. Randolph L. Gordon, MD, MPH, Commissioner of Health, presented his final report on the Department of Health's study on quality of care oversight. Lastly, Robert A. Archer, President of Virginia Health Information (VHI), presented VHI's 1997 annual report.

December 16th Meeting

The final Point-of-Service, Indigent/Uninsured, and Long-Term Care Subcommittee reports were presented at the December 16th meeting. Following the Point-of-Service Subcommittee report, proponents and opponents of "point-of-service" legislation presented their views on this topic.

Staff presented an overview of a decision matrix which outlined each of the various issues studied by the Joint Commission throughout 1997, and identified potential legislation to be introduced during the 1998 Session of the General Assembly.

January 6, 1998 Meeting

At the January 6, 1998 meeting, staff reviewed the public comments received on the Joint Commission's draft legislative proposals. The Commission made final decisions on proposed legislation and adopted its

package of legislative proposals and budgetary recommendations to be introduced during the 1998 Session.

INDIVIDUAL STUDY REPORTS PUBLISHED BY THE JOINT COMMISSION ON HEALTH CARE

The Joint Commission conducted a number of studies throughout 1997. These studies were presented in the form of "issue briefs" to the Commission during its 1997 meetings. Copies of each issue brief were distributed to persons attending the meetings at which the study was presented to the Joint Commission, as well as to interested parties who requested copies. The issue briefs also are posted on the Joint Commission's home page on the Internet enabling persons to download the report for review and comment.

Public comments were received on the issue briefs and presented to the Commission members at the next meeting. Following the public comment period, each issue brief was finalized and printed as either a House or Senate Document. Figure 1 identifies each of the Joint Commission's 1997 studies which were printed as separate documents.

1998 LEGISLATIVE PROPOSALS

As a result of the work completed by the Joint Commission during 1997, a package of legislative proposals was introduced and approved during the 1998 Session of the General Assembly. The following paragraphs identify each legislative proposal. A copy of each bill and resolution approved by the General Assembly is provided in Appendix A with the page numbers identified below.

Bills

SB 433/ HB 1074 — Establishes and implements the State Children's Health Insurance Program. While SB 433/HB 1074 were passed by the General Assembly, the Governor vetoed both measures. However, the Governor has indicated that he will implement the program according to corresponding language in the 1998 Appropriation Act. This legislation resulted from the Joint Commission's study on the indigent/uninsured published as 1998 Senate Document 43. (Appendix A, pages 1 and 61)

Related Budgetary Action: A total of $36.5 million in state funds were appropriated for the biennium to support the children's health insurance program.

Figure 1

1997 Individual Study Reports Published by the Joint Commission on Health Care

Name of Study	Authority for Study	House/Senate Document
High Risk Pools and Other Related Health Insurance Issues	SJR 337	Senate Document 25
Long-Term Care/ Aging Study	SJR 28	Senate Document 28
Continuing Care Retirement Communities	SB 1139	Senate Document 36
Indigent/Uninsured Study	SJR 298	Senate Document 43

Notes:

- Except as noted, all joint resolution and bill numbers are from the 1997 General Assembly Session. All House/Senate Document numbers are 1998 document numbers.
- A separate report was not published on the Point-of-Service study; this study is discussed in Chapter II of this Annual Report.

SB 463 Repeals the Code section that gives the Department for the Aging responsibility for coordinating long-term care at the state and local levels. This legislation resulted from the Joint Commission's study on long-term care and aging issues published as 1998 Senate Document 28. (Appendix A, page 5)

SB 464 Requires the Secretary of Health and Human Resources to coordinate the long-term care policy of the Commonwealth and develop and update annually a five-year plan for financing long-term care services. (Appendix A, page 6)

SB 465 Establishes the powers, duties, and membership of the current Governor's Advisory Board on Aging and changes the name of the Commonwealth Council on Aging. This legislation resulted from the Joint Commission's study on long-term care and aging issues published as 1998 Senate Document 28. (Appendix A, page 7)

SB 466 Codifies restrictions for nursing homes associated with Continuing Care Retirement Communities which file for their COPN outside of the State Medical Facilities Plan Request for Applications Process. This legislation resulted from the Joint Commission's study on continuing care retirement communities issues published as 1998 Senate Document 36. (Appendix A, page 15)

SB 498 Strengthens the adult protective services program. This legislation resulted from the Joint Commission's study on long-term care and aging issues published as 1998 Senate Document 28. (Appendix A, page 19)

SB 512 Exempts Community Health Centers from certain requirements of the Virginia Solicitation of Contributions Law to enhance their fund-raising capabilities. This legislation resulted from the Joint Commission's study on the indigent/uninsured published as 1998 Senate Document 43. (Appendix A, page 20)

SB 626 Provides authorization for full PACE programs and establishes operational, jurisdictional and regulatory parameters for pre-PACE and PACE programs. This legislation resulted from the Joint Commission's study on long-term care and aging issues published as 1998 Senate Document 28. (Appendix A, page 22)

HB 780 Grants the Commissioner of Social Services authority to more quickly impose intermediate sanctions on adult care residences. This legislation resulted from the Joint Commission's study on long-term care and aging issues published as 1998 Senate Document 28. (Appendix A, page 24)

HB 781 Enacts technical changes/clarifications to last year's Health Insurance Portability and Accountability Act (HIPAA) legislation. This legislation resulted from the Joint

Commission's study on health insurance issues published as 1998 Senate Document 25. (Appendix A, page 26)

HB 782 Provides an additional period of time for certain individuals to obtain coverage under HIPAA's "guaranteed issue" provision (Emergency Enactment). This legislation resulted from the Joint Commission's study on health insurance issues published as 1998 Senate Document 25. (Appendix A, page 41)

HB 854 Extends the modified community rating requirement for the Essential and Standard plans to groups up to 50 employees (formerly 25 employees). This legislation resulted from the Joint Commission's study on health insurance issues published as 1998 Senate Document 25. (Appendix A, page 42)

HB 855 Broadens the Bureau of Insurance's authority for regulating certain accident/sickness and life insurance policies which are issued out-of-state but cover Virginia residents. This legislation resulted from the Joint Commission's study on health insurance issues published as 1998 Senate Document 25. (Appendix A, page 50)

HB 1075 Requires HMOs to include a "point-of-service" (POS) option in all health care plan offerings. The POS option must be offered at the employee level with any additional costs to be paid by the POS enrollees. This legislation resulted from the Joint Commission's study on "point-of-service" plans as reported in Chapter II of this Annual Report. (Appendix A, page 65)

House Joint Resolutions (HJR) and Senate Joint Resolutions (SJR)

SJR 97/ HJR 156 — Requests the Joint Commission to continue its Long-Term Care Subcommittee and to complete its study on long-term care financing, licensure and other issues. These companion resolutions resulted from a Joint Commission study on long-term care and aging issues published as Senate Document 28. (Appendix A, pages 70 and 85)

Related Budgetary Action: A total of $65,000 general fund (GF) was appropriated to staff this study.

SJR 99 — Requests the Joint Commission to study the need for an ombudsman program and/or an external appeals mechanism for health insurance. (Appendix A, page 71)

SJR 104 — Requests the Joint Commission to study the costs and benefits of offering a tax incentive for long-term care insurance. This resolution resulted from a Joint Commission study on long-term care and aging issues published as Senate Document 28. (Appendix A, page 72)

SJR 105 — Requests the Virginia Retirement System to study the feasibility of offering long-term care insurance to state and local employees. This resolution resulted from a Joint Commission study on long-term care and aging issues published as Senate Document 28. (Appendix A, page 73)

SJR 112 — Directs the Department of Health to study opportunities for state agencies to support Free Clinics and Community Health Centers. This resolution resulted from a Joint Commission study on the indigent and uninsured published as Senate Document 43. (Appendix A, page 74)

SJR 119 — Requests the Department of Social Services and the Joint Commission to report on the implementation of recommendations made by a 1997 Joint Legislative Audit and Review Commission study of services for mentally disabled residents in adult care residences (ACRs) and other licensure issues. This resolution resulted from a Joint Commission study on long-term care and aging issues published as Senate Document 28. (Appendix A, page 76)

SJR 120 Requests the Department of Medical Assistance Services to study issues regarding Medicaid nursing home reimbursement. This resolution resulted from a Joint Commission study on long-term care and aging issues published as Senate Document 28. (Appendix A, page 77)

SJR 124/ HJR 202 Requests the Joint Commission and others to study pooled purchasing for small employers, Free Clinics and Community Health Centers. These companion resolutions resulted from a Joint Commission study on the indigent and uninsured published as Senate Document 43 and the "point-of-service" study. (Appendix A, pages 78 and 90)

SJR 125 Directs the Joint Commission to continue its study of issues regarding the indigent and uninsured. This resolution resulted from a Joint Commission study on the indigent and uninsured published as Senate Document 43. (Appendix A, page 80)

SJR 126 Directs the Joint Commission to continue its study of a high risk insurance pool in Virginia. This legislation resulted from the Joint Commission's study on high risk pools and other health insurance issues published as 1998 Senate Document 25. (Appendix A, page 82)

SJR 127/ HJR 180 Directs the Center for Pediatric Research to continue its research on pediatric care in Virginia. (Appendix A, pages 84 and 89)

Related Budgetary Action: A total of $75,000 GF was appropriated to support this study.

HJR 175 Directs the Commissioner of Health to take a lead role in sponsoring local health summits. This resolution resulted from a Joint Commission study on the indigent and uninsured published as Senate Document 43. (Appendix A, page 86)

HJR 179 Invites the health care foundations formed in Virginia as a result of not-for-profit hospitals converting to for-profit status to annually update the Joint Commission on their charitable activities. This resolution resulted from a Joint Commission study on the indigent and uninsured published as Senate Document 43. (Appendix A, page 88)

HJR 209 Requests JLARC to study the mission and effectiveness of the Virginia Department for the Aging. This resolution resulted from a Joint Commission study on long-term care and aging issues published as Senate Document 28. (Appendix A, page 92)

HJR 210 Requests the Joint Commission to study reimbursement and quality of care issues related to telemedicine. (Appendix A, page 93)

HJR 224 Requests the Department of Health to study the nursing home survey process for federal certification. This resolution resulted from a Joint Commission study on long-term care and aging issues published as Senate Document 28. (Appendix A, page 94)

II. "POINT-OF-SERVICE" HEALTH INSURANCE PLANS

"Point-of-Service" Plans Provide Health Insurance Benefits For Services Received Outside Of A Health Maintenance Organization's Provider Panel

Throughout the late 1980s and 1990s, employers increasingly have turned to managed care plans, particularly health maintenance organizations (HMOs), to help control rising health care costs. HMOs are better able to control costs than traditional types of insurance by managing more closely the care received by enrollees. In most HMO plans, enrollees generally must access health care services from providers participating in the plan's provider panel in order to receive benefits. Except in limited circumstances, enrollees in closed panel HMOs receive no benefits when services are received outside of the provider panel.

While HMOs have been successful in holding down cost increases, there have been concerns voiced by some patient advocates and providers that enrollees should have greater freedom in accessing care from non-participating providers. Also, employers have demanded that HMOs offer a managed care plan with greater provider choice as an insurance benefit option for their employees.

In response to these market demands, "point-of-service" (POS) plans have been developed by HMOs to provide benefits, albeit at a lower level or with greater co-payments, when services are received outside of the HMO's provider panel.

Proponents Believe A POS Mandate Is Needed To Ensure Patients Have The Ability To Receive Care From The Provider Of Their Choice; Opponents Believe The Market Already Provides Access To POS Plans And That A Mandate Will Raise Costs

While the market has responded to the demand for greater access to non-participating providers, proponents believe that a POS mandate is needed. These proponents argue that a mandate should be enacted to ensure that all patients have the ability to access care from the provider of their choice and that the mandate should be structured such that the POS offer is made at the employee level. Proponents believe that offering POS only at the employer level (i.e., the employer, not the employee, decides whether to

accept or decline the POS offer) does not ensure each employee has the option to enroll in the plan of his/her choice. Proponents also believe that any additional costs associated with the mandate should be borne by those enrollees selecting the POS option.

On the other hand, opponents of a POS mandate argue that the market already provides access to POS plans and that a mandate is unnecessary. Opponents also contend that health insurance costs will increase if a POS mandate is enacted which, in turn, will cause some small employers to drop coverage altogether. Lastly, opponents argue that a POS mandate likely would violate the provisions of the Employee Retirement Income Security Act (ERISA).

Senate Joint Resolution 297 And House Joint Resolution 631 Of The 1997 Session Of The General Assembly Directed The Joint Commission On Health Care To Study Various Issues Regarding A "Point-of-Service" Requirement

The 1997 Session of the General Assembly adopted Senate Joint Resolution (SJR) 297 and House Joint Resolution (HJR) 631 which directed the Joint Commission on Health Care to establish a task force to study various issues regarding whether HMOs should be required to offer a POS plan. These resolutions also directed the task force, working with the Joint Commission, to develop options to enhance the opportunity of Virginia businesses to offer employees the choice of participating in a POS plan without increasing the employer's contribution to health benefits.

SJR 297/HJR 631 directed the task force to examine various issues regarding POS plans, including, but not limited to the following:

- premium differentials and administrative charges of the closed panel HMO and POS plans;
- copayments, deductibles and other cost-sharing issues;
- the comparability of benefits levels between the closed panel HMO and POS plans;
- reimbursement of providers within/outside an HMO's panel;
- participation levels/criteria and underwriting considerations;
- disclosure of information to enrollees;
- process or conditions for employees selecting a POS plan;
- whether the Employee Retirement Income Security Act (ERISA) or the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have any impact on a POS requirement; and
- other options for enhancing consumer choice of health benefit plans, such as pooled purchasing.

In addition to the above issues, the study resolutions required an actuarial analysis of how to isolate the additional cost of a POS option on enrollees and whether such an approach can be implemented without increasing employers' cost of providing health benefits.

The Joint Commission's "POS" Task Force Met Four Times, Reviewed Various Information And Issues Regarding POS Plans, And Made Recommendations To The Joint Commission

As required by SJR 297/HJR 631, a POS Task Force was established to review various issues regarding POS plans and make recommendations to the full Joint Commission. The Task Force included Joint Commission members and representatives of consumers, businesses, insurers and providers. Figure 2 identifies the Task Force members who were appointed by Joint Commission Chairman Stanley C. Walker.

Figure 2
"Point-of-Service" Task Force Members

Task Force Member	Organization/Affiliation
The Honorable Kenneth R. Melvin (Chairman)	Joint Commission on Health Care
The Honorable Jay W. DeBoer	Joint Commission on Health Care
The Honorable Harvey B. Morgan	Joint Commission on Health Care
The Honorable William T. Bolling	Joint Commission on Health Care
The Honorable Stanley C. Walker (ex-officio)	Joint Commission on Health Care
Sandra D. Bowen	Virginia Chamber of Commerce
Thomas G. Goddard	Virginia Association of HMOs
Dr. Stanley L. Jason	Optometrist
C. Burke King	Trigon, Blue Cross Blue Shield
William L. Lukhard	American Association of Retired Persons
Linda Powell	Virginia Mental Health Consumers Association, Virginia Quality Health Care Network
Martha B. Pulley	Virginia Association for Home Care
Douglas M. Thompson	Tidewater Health Care
J. Latane Ware, M.D.	Medical Society of Virginia
Cynthia L. W. Warriner	Virginia Pharmacists Association
Katherine M. Webb	Virginia Hospital and Healthcare Association
Leslie S. Webb, Jr., D.D.S.	Virginia Dental Association

- *August 14, 1997 Task Force Meeting:* At the initial meeting, the Task Force reviewed information from a 1996 POS study conducted by the Joint Commission; reviewed some national and Virginia-specific

information regarding POS plans; and reviewed/discussed the 1997 study workplan. Gordon R. Trapnell, who was hired to serve as an actuarial consultant to the Task Force, also presented a workplan for his actuarial analysis.

- *October 15, 1997 Task Force Meeting:* At the October 15, 1997 meeting, information on POS mandates in other states and the availability of POS plans in Virginia was presented to the Task Force. Mr. Trapnell also presented his actuarial analysis regarding the cost of a POS mandate. Public comments were solicited on the information presented at this meeting.

- *October 27, 1997 Task Force Meeting:* At the October 27, 1997 meeting, a summary of the public comments received on the information presented at the October 15th meeting was presented. Also, the Task Force reviewed information regarding the impact of the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on POS. Information on health insurance purchasing cooperatives also was presented. Sandra Bowen presented the results of an employer insurance survey. An analysis of a POS proposal by the Medical Society of Virginia also was presented. Lastly, the Task Force reviewed several Policy Options regarding which action(s) to recommend to the full Commission. Public comments were requested on the various Policy Options presented to the Task Force.

- *November 19, 1997 Task Force Meeting:* At the November 19, 1997 meeting, the Task Force reviewed a summary of the public comments received on the Policy Options and voted on its recommendations to the Joint Commission.

The following pages summarize the information presented to the POS Task Force and the Task Force's deliberations on the issue of whether HMOs should be required to offer a POS option.

POS Plans Have Grown Substantially Across the Nation

It was only several years ago that POS plans were virtually unheard of in the health insurance marketplace. However, across the nation, POS plans have experienced rapid growth in response to market demands for enhanced choice of providers. This trend is evidenced by the fact that in 1992 only 8% of all health plan enrollments were in POS plans; this percentage doubled to 16% by 1996 (KPMG Peat Marwick).

Eleven States And The District Of Columbia Have Enacted A "Point-of-Service" Mandate

In an effort to make POS plans more available to their citizens, eleven states and the District of Columbia have enacted various laws requiring HMOs to offer a POS option. Figure 3 identifies these jurisdictions and the year in which their respective POS mandates were enacted.

Figure 3
State "POS" Mandates

Jurisdiction	Year Enacted	Jurisdiction	Year Enacted
District of Columbia	1996	Montana	1997
Georgia	1996	New Jersey	1997
Idaho	1997	New York	1994
Iowa	1997	Oklahoma	1997
Maryland	1995	Oregon	1995
Minnesota	1996	Texas	1997

Source: JCHC Staff Analysis of State Insurance Laws

As seen in Figure 3, POS laws in other states have been enacted within the past few years with nine laws being enacted in 1996 or 1997. Given the recent enactment of these laws, there is little or no information to gauge the impact these laws have had on the marketplace.

In eight of the 12 states, the POS mandate is at the employer level. In other words, the HMO must offer a POS option to each employer; the employer then decides whether to accept or decline the POS option. In three of the eight states (Maryland, Oklahoma, and Texas), the POS mandate is limited to those instances in which the employer/group is offering only an HMO plan. In these states, if other "non-HMO" plans are being offered by the employer, the POS mandate does not apply.

Four Jurisdictions (District of Columbia, Georgia, Iowa and Idaho) Require POS To Be Available At The Employee/Subscriber Level

While eight jurisdictions' POS mandates are at the employer level, the remaining four jurisdictions require the POS option to be offered at the employee level. Officials in these states indicate that if an employer offers an HMO to its employees, it must also offer the POS option.

In Virginia, POS Plans Are Widely Available; All Members Of The Virginia Association Of Health Maintenance Organizations Currently Offer A POS Product; Few Virginia Employers Offer Only An HMO Plan

In Virginia, virtually all of the HMOs currently offer a POS product. The Virginia Association of Health Maintenance Organizations (VAHMO) conducted a survey of its member plans and found that all 21 HMO plans offer a POS product. Seventeen of the 21 HMO plans offer POS to small groups (2-49 employees); an additional 2 plans are awaiting Bureau of Insurance approval to market POS in the 2-49 group market. The 17 HMOs which currently offer POS products in the small group market also offer a "dual option" in which an employer can select both the HMO and POS products as plan options for its employees.

With the addition of POS and other forms of managed care plans, Virginia employers have a broad range of health plan options available to them. An employer survey sponsored by the Virginia Chamber of Commerce found that approximately 8% of employers offered only an HMO plan to their employees. All other employers offer either an HMO with another option or offer a single non-HMO plan.

An Actuarial Analysis Of POS Costs Concluded That POS Premiums For Mandated Offerings Will Be Substantially Higher Than Found In The Current Marketplace, But That For Most Groups There Will Be A Stable, Self-Supporting Premium Rate

A critical component of this study was an actuarial analysis of the cost impact of a POS mandate. The specific issue to be addressed was what the cost impact would be if each HMO was required to include a POS offering so that enrollees could enroll in either the HMO or the POS product. A key assumption in the overall actuarial analysis was that any additional POS cost would be paid by the POS enrollees and not the employer, HMO, or other "non-POS" enrollees.

Gordon Trapnell, the actuarial consultant hired by the Joint Commission, conducted an extensive analysis of such a POS mandate and the impact it would have on health insurance costs. Mr. Trapnell's key conclusions were as follows:

- an effective POS mandate requires specifying each of the key characteristics (maximum deductible and coinsurance rate minimum basis of payment, etc.) including how the maximum premium can be calculated;
- regulating the maximum premium that can be charged for the POS is especially difficult since enrollees over which it is calculated will change and depend on the rate charged;
- in most cases, the POS premiums for mandated offerings will be substantially higher than found in the market place under current conditions;
- for most groups, there will be a stable, self-supporting premium rate, in which some employees will enroll, but the rate will vary widely depending on the characteristics of the employment group and will tend to increase over time relative to the HMO rate;
- there is a small number of groups for which the added cost for a POS will be so high that no one will enroll; and
- there will be indirect effects of mandating a POS, such as making it more difficult for HMOs to maintain discounts and persuade physicians to participate in provider panels, which will increase the cost of HMO coverage over time.

Following Mr. Trapnell's analysis, questions were raised regarding the impact that a POS mandate would have on costs beyond those which are paid by the POS enrollees (e.g., additional costs that would be borne by HMO enrollees or employers). Mr. Trapnell noted that while there would be some additional costs, they would be very small and at a level that would be impossible to measure accurately.

POS Mandates Must Comply With Provisions Of The Employee Retirement Income Security Act (ERISA)

The Employee Retirement Income Security Act (ERISA) is a federal law which relates to state regulation of insurance, banking, securities and employee benefit plans (29 U.S.C. Section 1144). As such, ERISA has a direct impact on states' ability to regulate the health insurance market, including POS mandates.

ERISA is a very complex law and is the subject of numerous court cases which have attempted to discern precisely what states can and cannot do in terms of health insurance regulation. As such, there are differing opinions as to how ERISA would apply in certain instances. Nonetheless, it is clear that states can regulate the "business of insurance." However, ERISA preempts states from regulating employee benefit plans such as "self-funded" or "self-insured" arrangements where there is no contract of insurance.

In interpreting ERISA, the courts have found that state mandated benefit laws and preferred provider network laws regulate the "business of insurance" and are not preempted by ERISA. Placing a requirement on an employer to offer a specific type of insurance plan would be preempted by ERISA. However, a POS requirement that is mandated of all HMOs similar to other mandated benefit laws would not be preempted by ERISA.

Health Insurance Purchasing Cooperatives Provide Another Means Of Expanding Consumer Choice Of Health Plans

Typically, small groups and individuals are considered higher risks by insurance carriers, and, thus, face greater difficulty in obtaining affordable coverage. Health insurance purchasing cooperatives (HIPCs) have been formed in many parts of the country as a means of pooling the purchasing power of small groups and individuals. At least 20 states have enacted laws to establish HIPCs or encourage the development of private purchasing pools.

In a HIPC, claims are spread over a larger group which reduces the underwriting burden that one small group may have to assume. In addition to spreading risks, HIPCs reduce administrative costs and generally enable small groups and their employees to have a wider range of plan options. Accordingly, HIPCs may be one means by which POS plans can be made more available to small employers and individuals.

THE LOCAL CHOICE program, which is administered by the Department of Personnel and Training, functions as a HIPC for local governments, school divisions and constitutional officers. Localities which elect to join the program enjoy many of the purchasing advantages of a large group (i.e., the state employee group). In 1997, 180 localities representing approximately 21, 500 eligible enrollees were enrolled in the program.

In order for a HIPC to be successful in Virginia, there must be certain insurance market reforms in place to ensure the HIPC can compete in the broader marketplace. Based on the experiences of other states, further rating reforms, namely modified community rating on all products in the small group market, would be needed in Virginia prior to the formation of a HIPC.

Policy Options

After addressing the various issues included in SJR 297/HJR 631, the following four policy options were presented to the Task Force for its consideration:

- **Option I:** Recommend that the Joint Commission take no legislative action.
- **Option II:** Recommend that the Joint Commission take the necessary steps to establish a health insurance purchasing cooperative or encourage the establishment of private health insurance purchasing cooperatives that would provide a choice of health benefits plans at the employee level. A study resolution to request an analysis of whether THE LOCAL CHOICE program could be expanded to include small businesses would be among the actions taken by the Joint Commission.
- **Option III:** Recommend that the Joint Commission introduce legislation to require HMOs to offer a "point-of-service" (POS) product at the employer level, which would allow the employer to decide whether to accept or decline the POS product.
- **Option IV:** Recommend the Joint Commission introduce legislation to require all HMOs to include a "point-of-service" (POS) option as a benefit component in all HMO products. The legislation would result in a POS option being available to all employees through prior enrollment in either the HMO or POS product. Employees choosing the POS option would pay for all additional costs associated with the POS benefits.

Public comments were solicited from interested parties on the four policy options. Following a presentation of a summary of these comments, the Task Force recommended that the Joint Commission pursue Options II and IV.

The Joint Commission On Health Care Introduced Legislation To Require HMOs To Offer A "Point-of-Service" Option At The Employee Level And A Joint Resolution To Study The Feasibility Of Implementing A Health Insurance Purchasing Cooperative In Virginia

The Joint Commission on Health Care supported the Task Force's recommendations and introduced legislation (House Bill 1075) to require that HMOs include a POS option in all health care plan offerings such that the offer is made at the employee level and that any additional costs are paid by the POS enrollees. The bill was passed by the 1998 Session of the General Assembly and signed by the Governor. A copy of HB 1075 is attached at Appendix A.

The Joint Commission also introduced Senate Joint Resolution 124 and House Joint Resolution 202 requesting the Joint Commission to study pooled purchasing arrangements as a means of improving the availability and affordability of health insurance for small employers and expanding employee choice of health plans. Both resolutions were adopted by the

1998 Session of the General Assembly. Copies of SJR 124 and HJR 202 are attached at Appendix A.

III. HEALTH CARE ISSUES FACING VIRGINIA AND THE NATION

In many respects, the health care issues currently facing Virginia and the nation are similar to those in past years. Improving the general health status of Virginians, increasing the number of persons with health insurance, controlling health care costs and improving the quality of care, and financing and providing for the long term care and aging needs of our older citizens all continue to be critical health care issues.

Each of these issues poses an important and continuing health care policy challenge. However, the new State Children's Health Insurance Program and those issues related to long-term care and aging are perhaps the most significant developments of 1997 and represent the most promising opportunities for improvement in 1998. While much was accomplished on these fronts in 1997 and during the 1998 Session of the General Assembly, ongoing efforts are needed to ensure continued progress in these areas.

This chapter provides an overview of these important issues as well as identifies other significant health care trends occurring in Virginia and across the nation.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Across the United States, there are approximately 10 million uninsured children. To address this problem, the U.S. Congress included the State Children's Health Insurance Program (SCHIP) in the Balanced Budget Act of 1997. Through the SCHIP initiative, Congress appropriated a total of $24 billion to help states expand health insurance coverage for children in families who cannot afford traditional health insurance coverage. Under SCHIP, uninsured children up to the age of 19 who live in families with annual incomes up to 200% of the federal poverty level (FPL) are eligible for the program.

The SCHIP initiative represents the most significant investment in children's health since the establishment of Medicaid. Through this program, the Commonwealth has an unprecedented opportunity to have a significant impact in reducing the number of uninsured Virginians.

Virginia Is Eligible To Receive Up To $68.7 Million Per Year In Federal SCHIP Funds To Provide Insurance Coverage To Uninsured Children

Federal SCHIP funds are allocated to the states in the form of an enhanced federal match rate for Medicaid. In Virginia, the current match rate is 51%; the enhanced match rate for children eligible for SCHIP is 66%. Virginia is eligible to receive up to $68.7 million per year in SCHIP funds provided that the Commonwealth appropriates the required $35.4 million in matching funds.

Approximately 858,000 Virginians are uninsured according to the 1996 Health Access Survey sponsored by the Virginia Health Care Foundation. Of this total, approximately 25% or 214,000 are children between the ages of 0 and 19. Based on an analysis of the 1996 Health Access Survey data, approximately 72,000 of the 214,000 uninsured children are eligible for SCHIP; an additional 82,300 children are eligible for Medicaid, but are not enrolled. Figure 4 illustrates the total number of uninsured children in Virginia and the number of children eligible for SCHIP.

Figure 4

Approximately 72,000 Of Virginia's Uninsured Children Are Eligible For SCHIP

Category	Number of Children
Total Uninsured Children (0-19)	214,000
Uninsured Children >200% of FPL	(59,900)
Uninsured Children Eligible/Not Enrolled in Medicaid	(82,300)
Uninsured Children Eligible For SCHIP	71,800

Source: JCHC Staff Analysis of 1996 Health Access Survey

Federal Law Provides States With Several Options For Implementing SCHIP; Virginia Will Expand Its Medicaid Program For Children In The Lowest Income Families, And Will Implement A Separate Program Using Medicaid Benefits And Income Methodologies For Children In Higher Income Families

Federal law provides states with several options for implementing SCHIP. The three basic approaches available to the states are: (i) expanding their existing Medicaid programs; (ii) implementing a separate program; or (iii) implementing a combination of a Medicaid expansion and a separate program.

Pursuant to language included in the 1998 Appropriation Act, the program being implemented in Virginia is a combination of approaches: children in families with incomes up to 150% of the FPL will be enrolled in Medicaid; children in families with incomes between 150% and 185% of the FPL will be enrolled in a separate program using Medicaid benefits and income methodologies. Families between 150% and 185% of the FPL will be required to pay premiums and co-pays on a sliding fee scale.

Virginia's SCHIP Initiative Is Expected To Provide Coverage To 83,360 Children in Fiscal Year 2000

Through the SCHIP initiative, the Commonwealth can provide health insurance to a total of 83,360 children, or nearly 10% of Virginia's uninsured population by fiscal year (FY) 2000.

The federal law requires that children found to be eligible for Medicaid through the outreach and enrollment process for SCHIP must be enrolled in Medicaid. It is estimated that approximately 32,800 of the 82,300 children eligible but not enrolled in Medicaid will be identified through the SCHIP outreach process and enrolled in Medicaid by FY 2000.

In addition to the 32,800 children eligible for but not enrolled in Medicaid, it is projected that 50,560 of the 72,000 newly eligible children will be enrolled in SCHIP by FY 2000. In all, an estimated 83,360 children are expected to have health insurance as a result of the SCHIP initiative.

Ongoing Efforts Are Needed To Ensure Virginia's SCHIP Initiative Is Meeting Its Objective Of Expanding Health Insurance Coverage To Uninsured Children

Virginia has invested approximately $36.8 million in SCHIP during the 1998-2000 biennium. It is critical that the Commonwealth continue to monitor the implementation and ongoing administration of its SCHIP

initiative to ensure that the program is meeting its objective of providing health insurance to uninsured children. It also will be important to track the degree to which SCHIP may be used by some families as a substitute for private coverage. Efforts will be needed to minimize the amount of "crowd-out" that may be occurring. The involvement of local child health and case management programs in the implementation and administration of SCHIP will be essential to ensure that this initiative functions in coordination with existing child health programs.

On a broader health care policy level, it will be important to track the impact that SCHIP is having on the health status of children in the program and the overall impact the program is having in reducing the number of uninsured persons in Virginia.

The SCHIP initiative provides an unprecedented opportunity to reduce Virginia's uninsured population. The Commonwealth has taken a major step forward by committing the necessary resources to implement this program. Throughout 1998 and the remainder of the 1998-2000 biennium, continuing attention to this issue will be needed to ensure that the Commonwealth's investment in children's health insurance is producing the desired results and is having a positive impact on the overall health status of Virginia's children.

ONGOING EFFORTS TO ADDRESS LONG-TERM CARE AND AGING ISSUES RESULTED IN THE FORMATION OF THE LONG-TERM CARE SUBCOMMITTEE

Long-term care and aging issues have become important national concerns because of the significant growth in the number of elderly Americans. Nationwide, people over age 85 are the fastest growing segment of the population. Similarly, in Virginia, people over 85 are the fastest growing segment of the population, and the percentage of Virginians age 85 or older is expected to double between 1990 and 2010. During the past five years, efforts at improving long-term care and aging services had focused on the consolidation of state agencies. However, none of the various consolidation proposals were adopted by the General Assembly and several long-term care and aging issues remained to be addressed.

At the direction of the 1997 General Assembly, the Joint Commission on Health Care formed a Long-Term Care Subcommittee to address outstanding long-term care and aging issues. As a result of the Subcommittee's deliberations during 1997, a number of long-term care initiatives were approved by the 1998 General Assembly. These included:

- SB 463, removes the responsibility for the Department for the Aging to coordinate long-term care at the state and local level;
- SB 464, makes the Secretary of Health and Human Resources responsible for coordinating long-term care at the state level;
- SB 465, creates the Commonwealth Council on Aging to replace the current Governor's Advisory Board on Aging;
- SB 466, creates a limited statutory exemption for nursing home beds within Continuing Care Retirement Communities with regard to the Request for Application aspect of the Certificate of Public Need Process;
- SB 498, strengthens the adult protective services program by clearly establishing in statute a role for the state Department of Social Services;
- SB 626, establishes the state regulatory framework for Program for All-Inclusive Care for the Elderly (PACE) programs and pre-PACE programs; and
- HB 780, gives the Commissioner of Social Services authority to more quickly impose intermediate sanctions for violations of adult care residence licensing regulations.

In addition, a budget amendment introduced by the Joint Commission on Health Care to expand Long-Term Care ombudsman services statewide was funded for $90,000 in each year of the biennium.

Remaining challenges to be addressed during the next year by the Long-Term Care Subcommittee include long-term care financing, licensure, and approaches for increasing the number of geriatricians in the state. With regard to long-term care financing, the Subcommittee will examine:

- the feasibility of a long-term care insurance program for state employees as an optional employee benefit;
- the costs and benefits of a long-term care insurance tax credit;
- options for better serving the dually eligible (individuals eligible for both Medicaid and Medicare); and
- creative waiver options for targeted long-term care populations.

As for long-term care licensure, issues to be examined by the Long-Term Care Subcommittee include:

- the feasibility of and the need for a separate Department of Health Care Quality;
- the potential for "deemed status" where accreditation of a facility would be accepted in lieu of state licensure; and
- the Virginia Department of Health's survey process for certification of nursing homes for participation in Medicaid and Medicare.

OTHER NATIONAL HEALTH CARE TRENDS

In addition to the State Children's Health Insurance Program and long-term care issues, several other national trends are important for Virginia health policy. These include: (i) the continued growth of managed care, (ii) decreased utilization of inpatient hospital care and increased emphasis on ambulatory care, (iii) slowing health care inflation, and (iv) the continued problem of the uninsured.

The percentage of Americans enrolled in managed care plans has significantly increased, while the number of Americans enrolled in indemnity insurance plans (fee-for-service plans) has correspondingly decreased. For example, the percentage of Americans receiving health insurance through their employer that were enrolled in traditional indemnity insurance plans decreased from 71 percent in 1988 to 18 percent in 1997. States are increasingly recognizing that the growth of managed care provides both opportunities and challenges. Opportunities include the potential for cost containment and improved quality of care. The challenge involves regulating health insurers to ensure both quality of care as well as the traditional focus on financial stability.

Partially as a result of the growth of managed care, utilization of inpatient hospital beds has been decreasing, while utilization of ambulatory care services has increased. For example, the number of hospital inpatient days per 1,000 in Virginia decreased from 781 in 1990 to 527 in 1996.

The growth of managed care and increased emphasis on ambulatory care have contributed to a slowing of health care inflation. From 1970 until the early 1990s, health care costs consistently rose at an annual rate of 10 percent or more. Health care costs also consistently grew at a faster rate than the overall inflation rate. However, during the past five years the rate of health care inflation has slowed, though it continues to outpace the overall inflation rate. In 1990 health care costs increased by 11 percent; in 1996 the increase in health care costs was 4.4 percent.

The slowing of health care inflation, however, has not helped reverse the trend of an increasing number of Americans lacking health insurance. In 1992 the number of Americans who lacked health insurance was estimated at 37 million. In 1997, the number of uninsured Americans was estimated at 41 million, notwithstanding the generally strong national economy during the period 1992-1997. While the State Children's Health Insurance Program will help address this problem among children, the problem of the uninsured will remain a significant issue for state health policy makers.

In Virginia, the Joint Commission on Health Care will continue to work in partnership with all those committed to addressing and solving these and other health care issues for the Commonwealth.

IMPACT OF MANAGED CARE ON ANCILLARY SERVICE PROVIDERS

Virginia's "Freedom of Choice " Law Was Enacted in 1994

The 1994 Session of the General Assembly passed House Bill 840 which provided that health insurers and health maintenance organizations (HMOs) issuing policies or contracts requiring use of network providers could not prohibit an enrollee from receiving pharmacy or ancillary medical services from the provider of his/her choice so long as the provider accepted the insurer/HMO's reimbursement as payment in full. This legislation commonly is referred to as Virginia's "freedom of choice" law.

While the term "ancillary medical services" was not defined in the statute, the Bureau of Insurance, through its regulatory authority, ruled that carriers and HMOs should interpret the term very broadly to include durable medical equipment companies, home health agencies, medical laboratories, and other related medical service providers.

"Freedom of Choice" Provisions Relating to Ancillary Medical Services Were Repealed in 1995

The General Assembly amended the "freedom of choice" law in 1995 (House Bill 2304) by repealing the provisions which had applied to ancillary service providers. In addition, a third enactment clause was included in HB 2304 directing the Joint Commission on Health Care to conduct a three-year study of ancillary medical services insofar as the availability and quality of these services are affected by managed care. The legislation directed the Joint Commission to include its findings in its 1996, 1997, and 1998 reports to the Governor and the General Assembly. This section of the Joint Commission's 1997 Annual Report represents the second phase of the three-year study.

Actions Taken By The 1998 Session Of The General Assembly Address The Issues Of Access To Providers And Quality Of Services

The 1998 Session of the General Assembly passed two pieces of legislation that address the issues raised in the study language regarding ancillary service providers. As discussed in Chapter II of this report, the 1998

General Assembly passed, and the Governor signed, House Bill 1075 which mandates that all HMOs include a "point-of-service" (POS) option in all health care plan offerings. The POS mandate will enable all enrollees to select a health plan that provides access to a greater number of providers. Through a POS option, enrollees have the choice of paying a higher premium and/or co-payment to gain access to the provider of their choice. While the POS requirement in HB 1075 is different from the "freedom of choice" provisions for pharmacy services, it should enhance enrollees' ability to access care from a broader array of ancillary service providers.

The 1998 General Assembly also passed Senate Bill 712 which provides a framework for statutory and regulatory oversight of managed care health insurance plans (MCHIPs). Under this legislation, the Virginia Department of Health (VDH) will oversee the quality of health care services provided by MCHIPs. As such, this legislation is more directly related to the issue of the availability and quality of ancillary medical services.

As part of its oversight and review of MCHIPs, VDH will examine various aspects of each plan to ensure the quality of care provided to enrollees, including: (i) complaint resolution and consumer satisfaction; (ii) access, availability and continuity of care; (iii) preventive care; (iv) credentialing; (v) consumer and provider education and awareness; (vi) utilization review; and (vii) improvement of community health status.

The passage of SB 712 provides for an ongoing assessment of the quality of health care services provided by managed care plans. The newly authorized functions of the VDH were established to identify and resolve problems that may arise regarding the availability and quality of health care services provided by MCHIPs, including ancillary medical services.

In addition to the legislation passed by the 1998 General Assembly, the Joint Commission will be conducting a study during 1998 pursuant to Senate Joint Resolution 99 regarding the need for an ombudsman program and/or external appeals mechanism for health insurance. This study will continue the Joint Commission's examination of other programs that may enhance the availability and quality of health care services in the managed care environment.

APPENDICES

APPENDIX A:

1998 Legislation

Joint Commission on Health Care
1998 Legislation
(As Approved)

Joint Commission on Health Care
1998 Legislation
(As Approved)

Joint Commission on Health Care
1998 Legislation
(As Approved)

Joint Commission on Health Care
1998 Legislation
(As Approved)

VIRGINIA ACTS OF ASSEMBLY -- CHAPTER

An Act to amend and reenact §§ 32.1-325, 32.1-351, and 32.1-352 of the Code of Virginia and to repeal § 32.1-353 of the Code of Virginia, relating to Virginia Children's Medical Security Insurance Plan.

[S 433]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§32.1-325, 32.1-351, and 32.1-352 of the Code of Virginia are amended and reenacted as follows:

§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 twenty-one, 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 $2,500 for the individual and an amount not in excess of $2,500 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 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 twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one 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 payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma or breast cancer 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. Regulations to implement this provision shall be effective in 280 days or less of the enactment of this subdivision. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process; ~~and~~

8. A provision to provide coverage to children up to the age of nineteen in compliance with the requirements of Title XXI of

the Social Security Act, as amended, and the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP) as established in Subtitle J of the federal Balanced Budget Act of 1997 (P.L. 105-33). This program shall be known as the Virginia Children's Medical Security Insurance Plan in accordance with Chapter 13 (§ 32.1-351 et seq.) of this title; and

~~8.~~ *9.* A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance.

In preparing the plan, the Board shall 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. The Board shall also initiate such cost containment or other measures as are set forth in the appropriations act. The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

The Board's regulations shall 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."

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 (§9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of §9-6.14:4.1, (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 which 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.

B. The Director of Medical Assistance Services is authorized to administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to 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.

C. The Director of Medical Assistance Services is authorized to 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.

The Director may refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony. In addition, the Director may 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.

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 (§9-6.14:1 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.

When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or 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 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. These regulations shall be effective within 280 days of July 1, 1996. The Board shall promulgate regulations for the reimbursement of licensed clinical nurse specialists to be effective

within 280 days of the enactment of this provision.

D. 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 as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen 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.

E. 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.

Except as provided in subsection I of §11-45, the provisions of the Virginia Public Procurement Act (§11-35 et seq.) shall not apply to the activities of the Director authorized by this subsection. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§32.1-351. Virginia Children's Medical Security Insurance Plan established.

A. The Department of Medical Assistance Services shall develop *and implement* the Virginia Children's Medical Security Insurance Plan to provide coverage for individuals, up to the age of ~~eighteen~~ *nineteen* , when such individuals (i) ~~are in families with~~ *have family* incomes at *or below* 200 percent of the *federal* poverty level ~~or less~~, *as set forth in the appropriation act*, and (ii) are ~~not insured or are underinsured by any policy, plan or contract providing health~~ *otherwise eligible for such* benefits *in compliance with Title XXI of the Social Security Act, as amended, and the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP) as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33).*

B. The Department of Medical Assistance Services shall develop ~~a proposal~~ *and submit to the federal Secretary of Health and Human Services a Title XXI plan* for this program ~~by December 1, 1997~~ *and may revise such plan as may be necessary. Such plan shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act.*

~~In developing this proposal, the Department shall consider, but need not limit its proposal to: (i) the services recommended by the American Academy of Pediatrics in its Child Health Insurance Reform Plan (CHIRP); (ii) the provision of services through a network of participating providers; (iii) the development of public/private partnerships; (iv) a schedule for providing universal coverage for uninsured and underinsured children in families with incomes at 200 percent of the poverty level or less, to be phased in over a period of five years; and (v) alternatives for soliciting or requiring contributions from employers. The Department shall also include in its proposal criteria for determining "underinsured."~~

C. Funding for this program shall be provided through *state and federal appropriations and may include appropriations of any funds which may be generated through* the Virginia Children's Medical Security Insurance Plan Trust Fund.

D. The Board of Medical Assistance Services may promulgate such regulations pursuant to the Administrative Process Act (§9-6.14:1 et seq.) as may be necessary for the implementation of the program ~~consistent with this chapter~~. *The first set of such regulations shall be promulgated by the Board to be effective within 280 days of the enactment of this provision.*

§32.1-352. Virginia Children's Medical Security Insurance Plan Trust Fund.

A. ~~For the purpose of providing primary and preventive care to certain individuals up to the age of eighteen.~~ There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Children's Medical Security Insurance Plan Trust Fund, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. The Fund shall consist of the premium differential, any employer contributions which may be solicited or received by the Department of Medical Assistance Services, and all grants, donations, gifts, and bequests from any source, public or private. As used in this section, "premium differential" means an amount equal to the difference between (i) 0.75 percent of the direct gross subscriber fee income derived from eligible contracts and (ii) the amount of license tax revenue generated pursuant to subdivision A 4 of §58.1-2501 with respect to eligible contracts. As used in this section, "eligible contract" means any subscription contract for any kind of plan classified and defined in §38.2-4201 or §38.2-4501 issued other than to (i) an individual or (ii) a primary small group employer if income from the contract is subject to license tax at the rate of 2.25 percent pursuant to subdivision D of §38.2-4229.1. The State Corporation Commission shall annually, on or before June 30, calculate the premium differential for the immediately preceding taxable year and notify the Comptroller of the Commonwealth to transfer such amount to the Virginia Children's Medical Security Insurance Plan Trust Fund as established on the books of the Comptroller.

B. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general

fund but shall remain in the Fund. Moneys in the Fund shall be used solely to support the Virginia Children's Medical Security Insurance Plan, ~~developed by the Department of Medical Assistance Services pursuant to §32.1-351. No more than five percent of such Fund may be used for administration~~ *in accordance with the requirements of Title XXI of the Social Security Act, as amended, and the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP), as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33).*

C. The Director of the Department of Medical Assistance Services shall report annually on December 1 to the Governor, the General Assembly, and the Joint Commission on Health Care on the status of the Fund, the number of children served *by this program* , the costs of such services, and any issues related to the Virginia Children's Medical Security Insurance Plan that may need to be addressed. ~~The first such report shall, however, consist of the proposal for implementation of the Virginia Children's Medical Security Insurance Plan as required by this chapter.~~

2. That §32.1-353 of the Code of Virginia is repealed.

3. That the Department of Medical Assistance Services shall submit and seek approval of a waiver from the federal Health Care Financing Administration (HCFA) to charge premiums and co-payments on a sliding scale for children whose family income is above 150 percent of the federal poverty level. Should the waiver not be approved by HCFA, the Department of Medical Assistance Services shall submit a Title XXI plan using Medicaid income methodologies and Medicaid benefits, but which charges premiums and co-payments on a sliding fee scale for children whose family income is above 150 percent of the federal poverty level.

CHAPTER 453

An Act to repeal § 2.1-373.4 of the Code of Virginia, relating to the Virginia Department for the Aging.

[S 463]

Approved April 14, 1998

Be it enacted by the General Assembly of Virginia:

1. That §2.1-373.4 of the Code of Virginia is repealed.

CHAPTER 793

An Act to amend and reenact § 2.1-51.14 of the Code of Virginia, relating to the Secretary of Health and Human Resources' responsibilities for long-term care coordination.

[S 464]
Approved April 22, 1998

Be it enacted by the General Assembly of Virginia:

1. That §2.1-51.14 of the Code of Virginia is amended and reenacted as follows:

§2.1-51.14. Subject to supervision by Governor; powers and duties.

A. The Secretary of Health and Human Resources shall be subject to direction and supervision by the Governor. The agencies assigned to the Secretary shall:

1. Exercise their respective powers and duties in accordance with the general policy established by the Governor or by the Secretary acting on behalf of the Governor;

2. Provide such assistance to the Governor or the Secretary as may be required; and

3. Forward all reports to the Governor through the Secretary.

B. Unless the Governor expressly reserves such power to himself, the Secretary is empowered to:

1. Resolve administrative, jurisdictional, operational, program, or policy conflicts between agencies or officials assigned;

2. Direct the formulation of a comprehensive program budget for the functional area identified in §2.1-398 encompassing the services of agencies assigned for consideration by the Governor;

3. Hold agency heads accountable for their administrative, fiscal and program actions in the conduct of the respective powers and duties of the agencies;

4. Direct the development of goals, objectives, policies and plans that are necessary to the effective and efficient operation of government;

5. Sign documents on behalf of the Governor which originate with agencies assigned to the Secretary; ~~and~~

6. Employ such personnel and to contract for such consulting services as may be required to perform the powers and duties conferred upon the Secretary by statute or executive order~~.~~*; and*

7. Coordinate the work of state agencies to implement the long-term care policy of the Commonwealth.

CHAPTER 665

An Act to amend and reenact §§ 2.1-1.7, 2.1-373 and 9-6.25:1 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 2.1-373.02, relating to the Commonwealth Council on Aging.

[S 465]

Approved April 16, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§2.1-1.7, 2.1-373 and 9-6.25:1 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 2.1-373.02 as follows:

§2.1-1.7. State councils.

A. There shall be, in addition to such others as may be established by law, the following permanent collegial bodies either affiliated with more than one agency or independent of an agency within the executive branch:

Adult Education and Literacy, Virginia Advisory Council for

Aging, Commonwealth Council on

Agricultural Council, Virginia

Alcohol and Drug Abuse Problems, Governor's Council on

Apprenticeship Council

Blue Ridge Regional Education and Training Council

Child Day-Care Council

Citizens' Advisory Council on Furnishing and Interpreting the Executive Mansion

Coastal Land Management Advisory Council, Virginia

Commonwealth Competition Council

Commonwealth's Attorneys' Services Council

Developmental Disabilities Planning Council, Virginia

Disability Services Council

Equal Employment Opportunity Council, Virginia

Housing for the Disabled, Interagency Coordinating Council on

Human Rights, Council on

Human Services Information and Referral Advisory Council

Indians, Council on

Interagency Coordinating Council, Virginia

Job Training Coordinating Council, Governor's

Land Evaluation Advisory Council

Maternal and Child Health Council

Military Advisory Council, Virginia

Needs of Handicapped Persons, Overall Advisory Council on the

Prevention, Virginia Council on Coordinating

Public Records Advisory Council, State

Rate-setting for Children's Facilities, Interdepartmental Council on

Revenue Estimates, Advisory Council on

Southside Virginia Marketing Council

Specialized Transportation Council

State Health Benefits Advisory Council

Status of Women, Council on the

Technology Council, Virginia

Virginia Business-Education Partnership Program, Advisory Council on the

Virginia Recycling Markets Development Council.

B. Notwithstanding the definition for "council" as provided in §2.1-1.2, the following entities shall be referred to as councils:

Council on Information Management

Higher Education, State Council of

Independent Living Council, Statewide

Rehabilitation Advisory Council, Statewide

Rehabilitation Advisory Council for the Blind, Statewide

Transplant Council, Virginia.

§2.1-373. Powers and duties of Department with respect to aging persons; area agencies on aging; Commonwealth Council on Aging.

(a) The mission of the Department for the Aging shall be to improve the quality of life for older Virginians; *in this chapter, older Virginians means persons aged sixty or older*. The Department's policies and programs shall be designed to enable older persons to be as independent and self-sufficient as possible. The Department shall promote local participation in programs for the aging, evaluate and monitor the services provided for older Virginians and provide information to the general public. In furtherance of this mission, the Department's duties shall include, but not be restricted to:

(1) To study the economic and physical condition of the residents in the Commonwealth whose age qualifies them for coverage under Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States, hereinafter referred to as the aging, and the employment, medical, educational, recreational and housing facilities available to them, with the view of determining the needs and problems of such persons;

(2) To determine the services and facilities, private and governmental and state and local, provided for and available to the aging and to recommend to the appropriate person or persons such coordination of and changes in such services and facilities as will make them of greater benefit to the aging and more responsive to their needs;

(3) To act as the single state agency, under Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States, and as the sole agency for administering or supervising the administration of such plans as may be adopted in accordance with the provisions of such law or laws. As such agency, the Department shall have authority to prepare, submit and carry out state plans and shall be the agency primarily responsible for coordinating state programs and

activities related to the purposes of, or undertaken under, such plans or laws;

(4) With the approval of the Governor, to apply for and expend such grants, gifts or bequests from any source as may become available in connection with its duties under this section, and is authorized to comply with such conditions and requirements as may be imposed in connection therewith;

(5) To hold such hearings and conduct such investigations as are necessary to pass upon applications for approval of a project under the plans and laws set out in *subdivision* (3) hereof, and shall make such reports to the Secretary of the United States Department of Health and Human Services as may be required;

(6) [Repealed.]

(7) To designate area agencies on aging pursuant to Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States and to promulgate rules and regulations for the composition and operation of such area agencies on aging;

(8), (9) [Repealed.]

(10) To provide information to consumers and their representatives concerning the recognized features of special care units. Such information shall educate consumers and their representatives on how to choose special care and may include brochures and electronic bulletin board notices.;

(11) To provide staff support to the Commonwealth Council on Aging;

(12) To serve as a focal point for research, policy analysis, long-range planning, and education on aging issues.

(b) The governing body of any county, city or town may appropriate funds for support of area agencies on aging designated pursuant to subdivision (a) (7) hereof.

(c) ~~The Governor is authorized to select such persons as may be qualified, as an advisory board, to assist the Department in the performance of the duties imposed upon it herein.~~

~~(d)~~ All agencies of the Commonwealth shall assist the Department in effectuating its functions in accordance with its designation as the single state agency as required in subdivision (a) (3) above.

§ 2.1-373.02 . Commonwealth Council on Aging; created; purpose; membership; terms; duties.

A. There is hereby created in the executive branch the Commonwealth Council on Aging, hereinafter referred to as the Council. The purpose of the Council shall be to promote an efficient, coordinated approach by state government to meeting the needs of older Virginians. The Council shall be composed of persons selected from the Commonwealth at large without regard to political affiliation but with due consideration of geographical representation. Appointees shall be selected for their ability, and all appointments shall be of such nature as to aid the work of the Council and to inspire the highest degree of cooperation and confidence.

B. The Council shall consist of nineteen voting members appointed as follows: one member from each of the eleven congressional districts of the Commonwealth appointed by the Governor subject to confirmation by a majority of each House of the General Assembly at its next regular session; four at-large members appointed by the Speaker of the House of Delegates; and four at-large members appointed by the Senate Committee on Privileges and Elections. The Council shall also include the following nonvoting, ex officio members: the Commissioner of the Department for the Aging, the Director of the Department of Medical Assistance Services, the Commissioner of Social Services and the Secretary of Health and Human Resources, or their designees. For initial appointments made by the Governor, the terms shall be as follows: five members shall serve four-year terms, four members shall serve three-year terms and two members shall serve two-year terms. For initial appointments made by the Speaker of the House of Delegates, two members shall be appointed for four-year terms and two members shall be appointed to two-year terms. For the initial appointments by the Senate Committee on Privileges and Elections, two members shall be appointed for four-year terms and two members shall be appointed for two-year terms. Thereafter, all appointments shall be for four-year terms.

In making initial appointments, the Governor, the Speaker of the House, and the Senate Committee on Privileges and Elections shall give due consideration to the appointment of members of the current Governor's Advisory Board on Aging.

Appointments to fill vacancies shall be for the unexpired term. No person having served on the Council for two consecutive terms shall be eligible for reappointment to the Council for two years thereafter.

C. The Council shall elect a chairman and a vice-chairman from among its members and shall appoint a secretary and such other officers as it deems necessary and prescribe their duties and terms of office.

D. The duties of the Council shall be as follows:

1. Examine the needs of older Virginians and ways in which state government can most effectively and efficiently assist in meeting those needs;

2. Advise the Governor and General Assembly on aging issues and aging policy for the Commonwealth;

3. Advise the Governor on any proposed regulations deemed by the Director of the Department of Planning and Budget to have a substantial and distinct impact on older Virginians. Such advice shall be provided in addition to other regulatory reviews required by the Administrative Process Act;

4. Advocate and develop the Commonwealth's planning for meeting the needs of the growing number of older Virginians; and

5. Advise the Governor and General Assembly regarding the activities of the Department.

E. The Council is authorized to apply for and expend such grants, gifts, or bequests from any source as may become available in connection with its duties under this section, and is authorized to comply with such conditions and requirements as may be imposed in connection therewith.

§9-6.25:1. Advisory boards, commissions and councils.

There shall be, in addition to such others as may be designated in accordance with §9-6.25, the following advisory boards, commissions and councils within the executive branch:

Advisory Board for the Department for the Deaf and Hard-of-Hearing

~~Advisory Board for the Department for the Aging~~

Advisory Board on Child Abuse and Neglect

Advisory Board on Medicare and Medicaid

Advisory Board on Occupational Therapy

Advisory Board on Physical Therapy to the Board of Medicine

Advisory Board on Rehabilitation Providers

Advisory Board on Respiratory Therapy to the Board of Medicine

Advisory Board on Teacher Education and Licensure

Advisory Commission on the Virginia Schools for the Deaf and the Blind

Advisory Council on Revenue Estimates

Advisory Council on the Virginia Business-Education Partnership Program

Appomattox State Scenic River Advisory Board

Aquaculture Advisory Board

Art and Architectural Review Board

Board for the Visually Handicapped

Board of Directors, Virginia Truck and Ornamentals Research Station

Board of Forestry

Board of Military Affairs

Board of Rehabilitative Services

Board of Transportation Safety

Board of Trustees of the Family and Children's Trust Fund

Board of Visitors, Gunston Hall Plantation

Board on Veterans' Affairs

Catoctin Creek State Scenic River Advisory Board

Cave Board

Chickahominy State Scenic River Advisory Board

Clinch Scenic River Advisory Board

Coal Surface Mining Reclamation Fund Advisory Board

Coastal Land Management Advisory Council, Virginia

Commonwealth Competition Council

Commonwealth Council on Aging

Council on Indians

Council on the Status of Women

Debt Capacity Advisory Committee

Emergency Medical Services Advisory Board

Falls of the James Committee

Goose Creek Scenic River Advisory Board

Governor's Council on Alcohol and Drug Abuse Problems

Governor's Mined Land Reclamation Advisory Committee

Hemophilia Advisory Board

Human Services Information and Referral Advisory Council

Interagency Coordinating Council on Housing for the Disabled

Interdepartmental Board of the State Department of Minority Business Enterprise

Litter Control and Recycling Fund Advisory Board

Local Advisory Board to the Blue Ridge Community College

Local Advisory Board to the Central Virginia Community College

Local Advisory Board to the Dabney S. Lancaster Community College

Local Advisory Board to the Danville Community College

Local Advisory Board to the Eastern Shore Community College

Local Advisory Board to the Germanna Community College

Local Advisory Board to the J. Sargeant Reynolds Community College

Local Advisory Board to the John Tyler Community College

Local Advisory Board to the Lord Fairfax Community College

Local Advisory Board to the Mountain Empire Community College

Local Advisory Board to the New River Community College

Local Advisory Board to the Northern Virginia Community College

Local Advisory Board to the Patrick Henry Community College

Local Advisory Board to the Paul D. Camp Community College

Local Advisory Board to the Piedmont Virginia Community College

Local Advisory Board to the Rappahannock Community College

Local Advisory Board to the Southside Virginia Community College

Local Advisory Board to the Southwest Virginia Community College

Local Advisory Board to the Thomas Nelson Community College

Local Advisory Board to the Tidewater Community College

Local Advisory Board to the Virginia Highlands Community College

Local Advisory Board to the Virginia Western Community College

Local Advisory Board to the Wytheville Community College

Maternal and Child Health Council

Medical Advisory Board, Department of Motor Vehicles

Migrant and Seasonal Farmworkers Board

Motor Vehicle Dealer's Advisory Board

North Meherrin State Scenic River Advisory Board

Nottoway State Scenic River Advisory Board

Personnel Advisory Board

Plant Pollination Advisory Board

Private College Advisory Board

Private Enterprise Commission

Private Security Services Advisory Board

Psychiatric Advisory Board

Radiation Advisory Board

Rappahannock Scenic River Advisory Board

Recreational Fishing Advisory Board, Virginia

Reforestation Board

Rockfish State Scenic River Advisory Board

Shenandoah State Scenic River Advisory Board

Small Business Advisory Board

Small Business Environmental Compliance Advisory Board

St. Mary's Scenic River Advisory Committee

State Advisory Board for the Virginia Employment Commission

State Advisory Board on Air Pollution

State Building Code Technical Review Board

State Health Benefits Advisory Council

State Land Evaluation Advisory Council

State Networking Users Advisory Board

State Public Records Advisory Council

Statewide Independent Living Council

Statewide Rehabilitation Advisory Council

Statewide Rehabilitation Advisory Council for the Blind

Staunton Scenic River Advisory Committee

Telecommunications Relay Service Advisory Board

Virginia-Israel Advisory Board

Virginia Advisory Commission on Intergovernmental Relations

Virginia Advisory Council for Adult Education and Literacy

Virginia Coal Mine Safety Board

Virginia Coal Research and Development Advisory Board

Virginia Commission for the Arts

Virginia Commission on the Bicentennial of the United States Constitution

Virginia Correctional Enterprises Advisory Board

Virginia Council on Coordinating Prevention

Virginia Equal Employment Opportunity Council

Virginia Geographic Information Network Advisory Board

Virginia Interagency Coordinating Council

Virginia Military Advisory Council

Virginia Public Buildings Board

Virginia Recycling Markets Development Council

Virginia Technology Council

Virginia Transplant Council

Virginia Veterans Cemetery Board

Virginia Water Resources Research Center, Statewide Advisory Board

Virginia Winegrowers Advisory Board.

CHAPTER 794

An Act to amend and reenact §§ 32.1-102.3:2 and 32.1-102.4 of the Code of Virginia and to repeal § 32.1-102.3:2.1 of the Code of Virginia, relating to certificates of public need.

[S 466]
Approved April 22, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§32.1-102.3:2 and 32.1-102.4 of the Code of Virginia are amended and reenacted as follows:

§32.1-102.3:2. Certificates of public need; applications for increases in nursing home bed supplies to be filed in response to Requests For Applications (RFAs).

A. Except for applications for continuing care retirement community nursing home bed projects filed by continuing care providers registered with the State Corporation Commission pursuant to Chapter 49 (§38.2-4900 et seq.) of Title 38.2 *which comply with the requirements established in this section* , the Commissioner of Health shall only approve, authorize or accept applications for the issuance of any certificate of public need pursuant to this article for any project which would result in an increase in the number of beds *in a planning district* in which nursing facility or extended care services are provided when such applications are filed in response to Requests For Applications (RFAs).

B. The Board of Health shall adopt regulations establishing standards for the approval and issuance of Requests for Applications by the Commissioner of Health. The standards shall include, but shall not be limited to, a requirement that determinations of need take into account any limitations on access to existing nursing home beds in the planning districts. The RFAs, which shall be published at least annually, shall be jointly developed by the Department of Health and the Department of Medical Assistance Services and based on analyses of the need, or lack thereof, for increases in the nursing home bed supply in each of the Commonwealth's planning districts in accordance with standards adopted by the Board of Health by regulation. The Commissioner shall only accept for review applications in response to such RFAs which conform with the geographic and bed need determinations of the specific RFA.

C. Sixty days prior to the Commissioner's approval and issuance of any Request For Applications, the Board of Health shall publish the proposed RFA in the Virginia Register for public comment together with an explanation of (i) the regulatory basis for the planning district bed needs set forth in the RFA and (ii) the rationale for the RFA's planning district designations. Any person objecting to the contents of the proposed RFA may notify, within fourteen days of the publication, the Board and the Commissioner of his objection and the objection's regulatory basis. The Commissioner shall prepare, and deliver by registered mail, a written response to each such objection within two weeks of the date of receiving the objection. The objector may file a rebuttal to the Commissioner's response in writing within five days of receiving the Commissioner's response. If objections are received, the Board ~~shall~~ *may* , after considering the provisions of the RFA, any objections, the Commissioner's responses, and if filed, any written rebuttals of the Commissioner's responses, hold a public hearing to receive comments on the specific RFA. Prior to making a decision on the Request for Applications, the Commissioner shall consider any recommendations made by the Board.

D. Except for a continuing care retirement community applying for a certificate of public need pursuant to provisions of subsections A, B, and C above, applications for continuing care retirement community nursing home bed projects shall be accepted by the Commissioner of Health only if the following criteria are met: (i) the facility is registered with the State Corporation Commission as a continuing care provider pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2, (ii) the number of new nursing home beds requested in the initial application does not exceed the lesser of twenty percent of the continuing care retirement community's total number of beds that are not nursing home beds or sixty beds, (iii) the number of new nursing home beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed twenty percent of its total number of beds that are not nursing home beds, and (iv) the continuing care retirement community has established a qualified resident assistance policy.

E. The Commissioner of Health may approve an initial certificate of public need for nursing home beds in a continuing care retirement community not to exceed the lesser of sixty beds or twenty percent of the total number of beds that are not nursing home beds which authorizes an initial one-time, three-year open admission period during which the continuing care retirement community may accept direct admissions into its nursing home beds. The Commissioner of Health may approve a certificate of public need for nursing home beds in a continuing care retirement community in addition to those nursing home beds requested for the initial one-time, three-year open admission period if (i) the number of new nursing home beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed twenty percent of its total number of beds that are not nursing beds, (ii) the number of licensed nursing home beds within the continuing care retirement community does not and will not exceed twenty percent of the number of

occupied beds that are not nursing beds, and (iii) no open-admission period is allowed for these nursing home beds. Upon the expiration of any initial one-time, three-year open admission period, a continuing care retirement community which has obtained a certificate of public need for a nursing facility project pursuant to subsection D may admit into its nursing home beds (i) a standard contract holder who has been a bona fide resident of the non-nursing home portion of the continuing care retirement community for at least thirty days, or (ii) a person who is a standard contract holder who has lived in the non-nursing home portion of the continuing care retirement community for less than thirty days but who requires nursing home care due to change in health status since admission to the continuing care retirement community, or (iii) a person who is a family member of a standard contract holder residing in a non-nursing home portion of the continuing care retirement community.

F. Any continuing care retirement community applicant for a certificate of public need to increase the number of nursing home beds shall authorize the State Corporation Commission to disclose such information to the Commissioner as may be in the State Corporation Commission's possession concerning such continuing care retirement community in order to allow the Commissioner of Health to enforce the provisions of this section. The State Corporation Commission shall provide the Commissioner with the requested information when so authorized.

G. For the purposes of this section:

"Family member" means spouse, mother, father, son, daughter, brother, sister, aunt, uncle or cousin by blood, marriage or adoption.

"One-time, three-year open admission period" means the three years after the initial licensure of nursing home beds during which the continuing care retirement community may take admissions directly into its nursing home beds without the signing of a standard contract. The facility or a related facility on the same campus shall not be granted any open admissions period for any subsequent application or authorization for nursing home beds.

"Qualified resident assistance policy" means a procedure, consistently followed by a facility, pursuant to which the facility endeavors to avoid requiring a resident to leave the facility because of inability to pay regular charges and which complies with the requirements of the Internal Revenue Service for maintenance of status as a tax exempt charitable organization under § 501 (c) (3) of the Internal Revenue Code. This policy shall be (i) generally made known to residents through the resident contract and (ii) supported by reasonable and consistent efforts to promote the availability of funds, either through a special fund, separate foundation or access to other available funds, to assist residents who are unable to pay regular charges in whole or in part.

This policy may (i) take into account the sound financial management of the facility, including existing reserves, and the reasonable requirements of lenders and (ii) include requirements that residents seeking such assistance provide all requested financial information and abide by reasonable conditions, including seeking to qualify for other assistance and restrictions on the transfer of assets to third parties.

A qualified resident assistance policy shall not constitute the business of insurance as defined in Chapter 1 (§ 38.2-100 et seq.) of Title 38.2.

"Standard contract" means a contract requiring the same entrance fee, terms, and conditions as contracts executed with residents of the non-nursing home portion of the facility, if the entrance fee is no less than the amount defined in § 38.2-4900 .

H. This section shall not be construed to prohibit or prevent a continuing care retirement community from discharging a resident (i) for breach of nonfinancial contract provisions, (ii) if medically appropriate care can no longer be provided to the resident, or (iii) if the resident is a danger to himself or others while in the facility.

I. The provisions of subsections D, E, and H of this section shall not affect any certificate of public need issued prior to July 1, 1998; however, any certificate of public need application for additional nursing home beds shall be subject to the provisions of this act.

§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;~~ or~~

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. ~~Notwithstanding the authority of the Commissioner to grant an extension of a schedule for completion of the project pursuant to subsection A of this section, no extension shall be granted for any nursing home bed project beyond June 30, 1992. However, the Commissioner may grant an extension of a schedule for completion for an additional nine months upon determining that (i) substantial and continuing progress has been made toward completion of the project; (ii) the project owner had agreed in writing prior to February 13, 1991, to delay the project to facilitate cost savings for the Commonwealth; and (iii) construction of the project was initiated on or before April 15, 1992. The Commissioner may also grant an extension of a schedule for completion for an additional six months to project owners who did not agree in writing prior to February 13, 1991, to delay their projects upon determining that (i) substantial and continuing progress has been made toward completion of the project and (ii) construction of the project was initiated on or before April 15, 1992. The certificate for any such nursing home bed project approved prior to January 1, 1991, which has not been completed by June 30, 1992, or by the expiration date of any approved extension, which in no case shall be later than March 31, 1993, shall be revoked. However, the Commissioner shall not revoke the certificate of public need for:~~

~~1. Any nursing home bed project for sixty beds proposed as part of a retirement community that is not a continuing care provider as defined in §38.2-4900 if (i) the certificate of public need was issued after May 1, 1988, and was in force on November 1, 1991, (ii) construction of the nursing home bed project is initiated by June 30, 1992, and (iii) the facility is completed by June 30, 1993.~~

~~2. Any nursing home bed project to add forty beds to an existing facility if (i) the project owner had agreed to delay the project to facilitate cost savings for the Commonwealth prior to February 13, 1991, (ii) the owner was seeking funding from the Department of Housing and Urban Development prior to February 13, 1992, (iii) the facility receives a feasibility approval for such funding from the Department of Housing and Urban Development by May 1, 1992, (iv) the facility closes a loan to fund the project by October 30, 1992, and (v) the facility is completed by October 31, 1993.~~

~~3. Any nursing home bed project for less than thirty beds proposed as part of a retirement community that is not a continuing care provider as defined in §38.2-4900 if (i) the certificate of public need was issued after May 1, 1988, and was in force on November 1, 1991, (ii) construction of the nursing home bed project was initiated before December 1, 1991, (iii) the owner of the nursing home bed project agrees in writing prior to July 1, 1992, to restrict use of the nursing home beds to residents of such retirement community, (iv) construction on the nursing home bed project that was not completed by August 27, 1991, is resumed by August 1, 1993, and (v) the nursing home bed project is completed by July 31, 1994.~~

~~E.~~ 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.

~~F.~~ *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.

~~G.~~ *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.

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.

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

2. That §32.1-102.3:2.1 of the Code of Virginia is repealed.

3. That any continuing care retirement community with a certificate of public need issued on August 1, 1997, shall be eligible for a one-time, eighteen-month open admission period for sixty beds.

CHAPTER 149

An Act to amend the Code of Virginia by adding a section numbered 63.1-55.02, relating to the creation of the Adult Protective Services Unit.

[S 498]
Approved March 16, 1998

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 63.1-55.02 as follows:

§ 63.1-55.02. Establishment of Adult Protective Services Unit; duties.

There is hereby created the Adult Protective Services Unit within the Adult Protective Services Program in the Department of Social Services, which shall have the following powers and duties:

1. To support, strengthen, and evaluate adult protective services programs at local departments of social services.

2. To assist in developing and implementing programs aimed at responding to and preventing abuse of aged and incapacitated adults.

3. To prepare, disseminate, and present educational programs and materials on adult abuse, neglect and exploitation.

4. To develop and provide educational programs and materials to persons who are required by law to make reports of adult abuse, neglect, and exploitation under this chapter.

5. To establish standards of training and provide educational opportunities to qualify workers in the field of adult protective services to determine whether reports of abuse, neglect, or exploitation of aged and incapacitated adults are substantiated.

6. To develop policies and procedures to guide the work of persons in the field of adult protective services.

7. To prepare and disseminate statistical information on adult protective services in Virginia.

8. To provide training and technical assistance to the adult protective services twenty-four-hour hotline.

9. To provide coordination among the adult protective services program and other state social services, medical and legal agencies.

CHAPTER 232

An Act to amend and reenact §§ 57-60 and 57-63 of the Code of Virginia, relating to the solicitation of contributions: exemptions.

[S 512]
Approved April 2, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§57-60 and 57-63 of the Code of Virginia are amended and reenacted as follows:

§57-60. Exemptions.

~~(a)~~ *A.* The following persons shall be exempt from the registration requirements of §57-49 and the requirements of §57-53, but shall otherwise be subject to the provisions of this chapter:

~~(1)~~ *1.* Educational institutions that are accredited by the Board of Education, by a regional accrediting association or by an organization affiliated with the National Commission on Accrediting, the Association Montessori Internationale, the American Montessori Society, the Virginia Independent Schools Association, or the Virginia Association of Independent Schools, any foundation having an established identity with any of the aforementioned educational institutions, and any other educational institution confining its solicitation of contributions to its student body, alumni, faculty and trustees, and their families.

~~(2)~~ *2.* Persons requesting contributions for the relief of any individual specified by name at the time of the solicitation when all of the contributions collected without any deductions whatsoever are turned over to the named beneficiary for his use.

~~(3)~~ *3.* Charitable organizations which do not intend to solicit and receive, during a calendar year, and have not actually raised or received, during any of the three next preceding calendar years, contributions from the public in excess of $5,000, if all of their functions, including fund-raising activities, are carried on by persons who are unpaid for their services and if no part of their assets or income inures to the benefit of or is paid to any officer or member. Nevertheless, if the contributions raised from the public, whether all of such ~~is~~ *are* or ~~is~~ *are* not received by any charitable organization during any calendar year, shall be in excess of $5,000, it shall, within thirty days after the date it has received total contributions in excess of $5,000, register with and report to the Commissioner as required by this chapter.

~~(4)~~ *4.* Organizations which solicit only within the membership of the organization by the members thereof.

~~(5)~~ *5.* Organizations which have no office within the Commonwealth, which solicit in the Commonwealth from without the Commonwealth solely by means of telephone or telegraph, direct mail or advertising in national media, and which have a chapter, branch, or affiliate within the Commonwealth which has registered with the Commissioner.

~~(6)~~ *6.* Health care institutions *defined herein as any facility* which ~~have~~ *has* been *(i)* granted tax-exempt status under § 501 (c) (3) of the Internal Revenue Code, *or (ii) designated by the Health Care Financing Administration (HCFA) as a federally qualified health center, or (iii) certified by the HCFA as a rural health clinic,* and any supporting organization which exists solely to support any such health care institutions.

~~(7)~~ *7.* Civic organizations as defined herein.

~~(8)~~ *8.* Nonprofit debt counseling agencies licensed pursuant to §6.1-363.1.

~~(9)~~ *9.* Agencies designated by the Virginia Department for the Aging pursuant to subdivision (a) (7) of §2.1-373 as area agencies on aging.

~~(10)~~ *10.* Labor unions, labor associations and labor organizations that have been granted tax-exempt status under § 501 (c) (5) of the Internal Revenue Code.

~~(11)~~ *11.* Trade associations that have been granted tax-exempt status under § 501 (c) (6) of the Internal Revenue Code.

~~(b)~~ *B.* A charitable organization shall be subject to the provisions of §§57-57 and 57-59, but shall otherwise be exempt from the provisions of this chapter for any year in which it confines its solicitations in this Commonwealth to five or fewer contiguous cities and counties, and in which it has registered under the charitable solicitations ordinance, if any, of each such city and county. No organization shall be exempt under this subsection if, during its next preceding fiscal year, more than ten percent of its gross receipts were paid to any person or combination of persons, located outside the boundaries of such cities

and counties, other than for the purchase of real property, or tangible personal property or personal services to be used within such localities. An organization which is otherwise qualified for exemption under this subsection which solicits by means of a local publication, or radio or television station, shall not be disqualified solely because the circulation or range of such medium extends beyond the boundaries of such cities or counties.

~~(c)~~ *C*. No charitable or civic organization shall be exempt under this section unless it submits to the Commissioner, who in his discretion may extend such filing deadline prospectively or retrospectively for good cause shown, on forms to be prescribed by him, the name, address and purpose of the organization and a statement setting forth the reason for the claim for exemption. Parent organizations may file consolidated applications for exemptions for any chapters, branches, or affiliates which they believe to be exempt from the registration provisions of this chapter. If the organization is exempted, the Commissioner shall issue a letter of exemption which may be exhibited to the public. A registration fee of ten dollars shall be required of every organization requesting an exemption after June 30, 1984. The letter of exemption shall remain in effect as long as the organization continues to solicit in accordance with its claim for exemption.

~~(d)~~ *D*. Nothing in this chapter shall be construed as being applicable to the American Red Cross or any of its local chapters.

§57-63. Local ordinances.

~~(a)~~ *A*. The governing body of any city, town or county may by ordinance not inconsistent with this chapter provide for the regulation and licensing of charitable or civic organizations soliciting within the city, town or county, and for penalties for violation thereof, subject to the following limitations:

~~(1)~~ *1*. No local license tax or fee in excess of ten dollars shall be required of any charitable organization.

~~(2)~~ *2*. No charitable organization exempt from registration under *subdivision A 1, A 4 or A 6 of* §57-60 ~~(a) or (4) or (6)~~ shall be required to be licensed. Any such organization may obtain a local license, without payment of any license tax or fee, upon compliance with all such requirements of the local ordinance as would have been applicable had it been registered with the Commissioner during each year in which it obtained an exemption letter under §57-60 ~~(c)~~ *C* .

~~(3)~~ *3*. No charitable organization which has registered with the Commissioner for the current and next preceding three years, or exempt for such years under §57-50, shall be required to provide any financial information.

~~(4)~~ *4*. No charitable or civic organization which solicits within this Commonwealth from a place outside the Commonwealth solely by telephone, telegraph, direct mail or advertising in national media, and having no chapter, branch, area or office within this Commonwealth, shall be required to be licensed.

~~(5)~~ *5*. No museum which has registered with the Commissioner as required by §57-49 and which has been granted tax-exempt status under § 501 (c) (3) of the Internal Revenue Code shall be required to comply with the regulation or licensing provisions of any local charitable solicitations ordinance.

~~(6)~~ *6*. If a charitable or civic organization shall designate by power of attorney filed with the Commissioner one or more persons authorized to sign on its behalf, the signature, verification or affirmation of any such persons shall be sufficient for all purposes of any local charitable solicitations ordinance.

~~(b)~~ *B*. Any ordinance adopted pursuant to this section may provide, inter alia, for procedures whereby charitable organizations may, for valid reasons, after an administrative hearing, be denied a local license or whereby a license may be revoked. Valid reasons for denial or revocation of a local license may be defined to include, without limitation, the expenditure of charitable assets for noncharitable purposes, any misrepresentation to the public or to any prospective donor, and any violation of state or local law. Any charitable organization which is denied a license may, within fifteen days from the date of such denial, apply for relief to the circuit court of such city or county or of the county in which such town is located. If the court is satisfied that the denial was for any reason erroneous, it shall provide such relief as may be appropriate.

~~(c)~~ *C*. No ordinance, or amendment thereto, adopted pursuant to this section shall be valid for any calendar year beginning after December 31, 1978, unless, before September 1 of that year, there shall have been filed with the Commissioner, on forms to be prescribed by him, information deemed by him to be sufficient for the purpose of advising charitable or civic organizations of the necessity for them to be licensed by such city, town or county.

~~(d)~~ *D*. No charitable organization shall be required to comply with the provisions of local ordinances if such organization has registered with the Commissioner or if such organization is a chapter, branch or affiliate included in the consolidated report of an organization or federated organization registered with the Commissioner, except that such charitable organization shall not be exempted from that portion of any local ordinance which requires such organization to register its name, the names of its solicitors and the dates and times that they will be soliciting in the locality.

CHAPTER 318

An Act to amend and reenact § 32.1-330.3 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-226.2, relating to medical assistance services; operation and oversight of pre-PACE and PACE plans.

[S 626]

Approved April 9, 1998

Be it enacted by the General Assembly of Virginia:

1. That §32.1-330.3 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-226.2 as follows:

§32.1-330.3. Operation of a pre-PACE plan or PACE plan; oversight by Department of Medical Assistance Services.

A. ~~1.~~ Operation of a pre-PACE plan *or PACE plan* that participates in the medical assistance services program must be in accordance with a prepaid health plan contract *or other PACE contract consistent with Chapter 6 of Title IV of the federal Balanced Budget Act of 1997* with the Department of Medical Assistance Services.

~~2.~~ *1.* As used in this section, ~~"pre-PACE plans" mean~~ *"pre-PACE" means of or associated with* long-term care prepaid health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act *(42 U.S.C. § 1396b et seq.)* and the state plan for medical assistance services as established pursuant to Chapter 10 (§32.1-323 et seq.) of ~~Title 32.1~~ *this title* and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

2. As used in this section, "PACE" means of or associated with long-term care health plans (i) authorized as programs of all-inclusive care for the elderly by Subtitle I (§ 4801 et seq.) of Chapter 6 of Title IV of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 528 et seq., §§ 4801-4804 , 1997, pursuant to Title XVIII and Title XIX of the United States Social Security Act (42 U.S.C. § 1395eee et seq.), and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of this title and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

B. All contracts and subcontracts shall contain an agreement to hold harmless the Department of Medical Assistance Services and pre-PACE ~~participants~~ *and PACE enrollees* in the event that a pre-PACE *or PACE* provider cannot or will not pay for services performed by the subcontractor pursuant to the contract or subcontract.

C. During the pre-PACE *or PACE* period, the ~~program~~ *plan* shall have a fiscally sound operation as demonstrated by total assets being greater than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due, and a plan for handling insolvency approved by the Department of Medical Assistance Services.

D. The pre-PACE *or PACE* plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event of insolvency:

1. One month's total capitation revenue to cover expenses the month prior to insolvency; and

2. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

The required arrangements to cover expenses shall be in accordance with the PACE Protocol as published by On Lok, Inc. in cooperation with the United States Health Care Financing Administration, as of April 14, 1995, or any successor protocol that may be agreed upon between the United States Health Care Financing Administration and On Lok, Inc.

Appropriate arrangements to cover expenses ~~must~~ *shall* include one or more of the following: reasonable and sufficient net worth, insolvency insurance, letters of credit or parental guarantees.

~~E. Pre-PACE plans which contract with private pay participants shall, at all times, hold in a segregated escrow account an amount at least equal to two months' capitation payment for each private pay participant of the pre-PACE site. Such amounts shall be in addition to any amounts or other arrangements required under subsection D and shall be used to assist the private pay participants in obtaining substitute services in the case of insolvency or other failure of the pre-PACE site.~~

~~1. Enrollment at any one pre-PACE site of private pay participants shall be limited to a maximum of five percent.~~

~~2. For the purposes of this section, "private pay participants" means those persons who do not participate in programs authorized pursuant to Title XVIII of the United States Social Security Act, or Title XIX of the United States Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§32.1-323 et seq.) of Title 32.1~~ *Enrollment in a pre-PACE or PACE plan shall be restricted to those individuals who participate in programs authorized pursuant to Title XIX or Title XVIII of the United States Social Security Act, respectively .*

F. Full disclosure shall be made to all ~~private pay participants, and to those~~ individuals in the process of enrolling in the pre-PACE ~~site, that the pre-PACE program is not insurance and should not be considered a substitute for insurance. In addition, disclosure shall include a statement~~ *or PACE plan* that services are not guaranteed beyond a thirty-day period.

G. The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license requirements, regulations and ongoing oversight. The Advisory Group shall include representatives from each of the following organizations: Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of Insurance, Board of Medicine, Board of Pharmacy, Department for the Aging, and a pre-PACE *or PACE* provider.

§ 38.2-226.2 . Provisions of title not applicable to certain long-term care health plans.

A. This title shall not apply to pre-PACE long-term care health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act (42 U.S.C. § 1396b et seq.) and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

B. This title shall not apply to PACE long-term care health plans (i) authorized as programs of all-inclusive care for the elderly by Subtitle I (§ 4801 et seq.) of Chapter 6 of Title IV of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 528 et seq., §§ 4801-4804 , 1997, pursuant to Title XVIII and Title XIX of the United States Social Security Act (42 U.S.C. § 1395eee et seq.) and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

C. Enrollment in a pre-PACE or PACE plan shall be restricted to those individuals who participate in programs authorized pursuant to Title XIX or Title XVIII of the United States Social Security Act, respectively.

CHAPTER 850

An Act to amend and reenact §§ 63.1-172, 63.1-179.1, and 63.1-180 of the Code of Virginia, relating to penalties for violations of licensing regulations for adult care residences.

[H 780]
Approved April 22, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§63.1-172, 63.1-179.1, and 63.1-180 of the Code of Virginia are amended and reenacted as follows:

§63.1-172. Definitions.

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

"Adult care residence" means any place, establishment, or institution, public or private, operated or maintained for the maintenance or care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Mental Health, Mental Retardation and Substance Abuse Services, but including any portion of such facility not so licensed, and (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage, and (iii) a facility or portion of a facility serving infirm or disabled persons between the ages of eighteen and twenty-one, or twenty-two if enrolled in an educational program for the handicapped pursuant to §22.1-214, when such facility is licensed by the Virginia Department of Social Services as a child-caring institution under Chapter 10 (§63.1-195 et seq.) of this title, but including any portion of the facility not so licensed. Included in this definition are any two or more places, establishments or institutions owned or operated by a single entity and providing maintenance or care to a combined total of four or more aged, infirm or disabled adults.

"Assisted living" means a level of service provided by an adult care residence for adults who may have physical or mental impairments and require at least a moderate level of assistance with activities of daily living.

"Independent physician" means a physician who is chosen by the resident of the adult care residence and who has no financial interest in the adult care residence, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the residence.

"Independently mobile" means a resident of an adult care residence who is physically and mentally able to exit the residence without assistance in an emergency and who can ascend or descend stairs if present in any necessary exit path.

"Maintenance or care" means the protection, general supervision and oversight of the physical and mental well-being of the aged, infirm or disabled individual.

"Nonambulatory" means a resident of an adult care residence who by reason of physical or mental impairment is unable to exit the residence in an emergency without the assistance of another person.

"Qualified assessor" means an entity contracting with the Department of Medical Assistance Services to perform nursing facility pre-admission screening or to complete the uniform assessment instrument for a home and community-based waiver program, including an independent physician contracting with the Department of Medical Assistance Services to complete the uniform assessment instrument for residents of adult care residences, or any hospital which has contracted with the Department of Medical Assistance Services to perform nursing facility pre-admission screenings.

"Residential living" means a level of service provided by an adult care residence for adults who may have physical or mental impairments and require only minimal assistance with the activities of daily living. This definition includes independent living facilities that voluntarily become licensed.

"Semimobile" means a resident of an adult care residence who because of physical or mental impairment requires limited assistance, such as the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command, to exit the residence in an emergency.

"Special order" means an administrative order issued to any party licensed pursuant to this chapter that has a stated duration of not more than twelve months and that may include a civil penalty that shall not exceed $500 for each inspection resulting in a finding of violation, a restriction or prohibition on admission of new residents to any adult care residence, and/or a reduction in licensed capacity of any adult care residence.

§63.1-179.1. Enforcement and sanctions.

The Board shall promulgate regulations for the Commissioner to use in determining when the imposition of administrative sanctions or initiation of court proceedings, severally or jointly, is appropriate in order to ensure prompt correction of violations involving noncompliance with state law or regulation as discovered through any inspection or investigation conducted by the Departments of Social Services, Health, or Mental Health, Mental Retardation and Substance Abuse Services. *Notwithstanding any other provision of law, following a proceeding as provided in § 9-6.14:11* , the Commissioner may ~~impose such sanctions or take such actions as are appropriate~~ *issue a special order* for violation of any of the provisions of this article, §54.1-3408, or any rule or regulation promulgated under any provision of this article which adversely impacts, *or is an imminent and substantial threat to*, the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in an adult care residence. ~~Such sanctions or actions may include (i) reducing the licensed capacity of any adult care residence, (ii) restricting or prohibiting new admissions to any adult care residence, (iii) petitioning the court to impose a civil penalty against any adult care residence or to appoint a receiver for the adult care residence, and (iv) revoking or denying renewal of the license for the adult care residence.~~ *The issuance of a special order shall be considered a case decision as defined in § 9-6.14:4 . The Commissioner shall not delegate his authority to impose civil penalties in conjunction with the issuance of special orders. The Commissioner shall also have the power to revoke or deny the renewal of the license for any adult care residence for violation of any of the provisions of this article. § 54.1-3408 . or any rule or regulation promulgated under any provision of this article which adversely impacts, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in an adult care residence.*

§63.1-180. Appeal from refusal, denial of renewal or revocation of license.

A. Whenever the Commissioner refuses to issue *a license* or to renew a license, *or revokes a license* for an adult care residence ~~or whenever the Commissioner revokes a license of an adult care residence, or imposes a sanction as provided in §63.1-179.1~~, the provisions of the Administrative Process Act (§9-6.14:1 et seq.) shall apply, except that all appeals from notice ~~of imposition of administrative sanctions, pursuant to §63.1-179.1,~~ *of the Commissioner's intent to refuse to issue or renew, or revoke a license* shall be received in writing from the adult care residence operator within fifteen days of the date of receipt of the notice. Judicial review of a final review agency decision shall be in accordance with the provisions of the Administrative Process Act. No stay may be granted upon appeal to the Virginia Supreme Court.

B. In every appeal to a court of record, the Commissioner shall be named defendant.

C. An appeal, taken as provided in this section, shall operate to stay any criminal prosecution for operation without a license.

D. When issuance or renewal of a license has been refused by the Commissioner, the applicant shall not thereafter for a period of one year apply again for such license unless the Commissioner in his sole discretion believes that there has been such a change in the conditions on account of which he refused the prior application as to justify considering the new application. When an appeal is taken by the applicant pursuant to subsection A above, the one-year period shall be extended until a final decision has been rendered on appeal.

CHAPTER 24

An Act to amend and reenact §§ 38.2-3430.2, 38.2-3430.4, 38.2-3430.6, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, 38.2-3435, 38.2-3514.2 and 38.2-3531 of the Code of Virginia, relating to health insurance; conformity with the Health Insurance Portability Act.

[H 781]
Approved March 9, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§38.2-3430.2, 38.2-3430.4, 38.2-3430.6, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, 38.2-3435, 38.2-3514.2 and 38.2-3531 of the Code of Virginia are amended and reenacted as follows:

§38.2-3430.2. Definitions.

A. The terms defined in §38.2-3431 that are used in this article shall have the meanings set forth in that section.

B. For purposes of this article:

"Eligible individual" means an individual:

1. (i) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is eighteen or more months, and (ii) whose most recent prior creditable coverage was under a group health plan, governmental plan or church plan or health insurance coverage offered in connection with any such plan;

2. Who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a state plan under Title XIX of such Act, or any successor program, and does not have other health insurance coverage;

3. With respect to whom the most recent coverage within the coverage period described in subdivision 1 was not terminated based on a factor described in subdivision B 1 or B 2 of §38.2-3430.7 relating to nonpayment of premiums or fraud;

4. If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage; and

5. Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

For the purposes of determining the aggregate of the periods of creditable coverage under subdivision B 1 (i) of this section, a period of creditable coverage shall not be counted with respect to enrollment of an individual under a health benefit plan if, after such period, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage or was not serving a waiting period for coverage under a group health plan, or for group health insurance coverage or was in an affiliation period.

§38.2-3430.4. Special rules for network plans.

A health insurance issuer that offers health insurance coverage in the individual market may:

1. Limit the *eligible* individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan;

2. Within the service area of such plan, deny such coverage to such individuals if the health insurance issuer has demonstrated to the Commission that: (i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders, enrollees and enrollees covered under individual contracts; and (ii) it is applying this section uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals;

3. A health insurance issuer, upon denying health insurance coverage in any service area in accordance with subdivision A 2, may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

§38.2-3430.6. Market requirements.

A. The provisions of § ~~38.2-3427~~ *38.2-3430.3* shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

B. A health insurance issuer offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

§38.2-3431. Application of article; definitions.

A. This article applies to group health plans and to health insurance issuers offering group health insurance coverage, and individual policies offered to employees of small employers.

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in this Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met.

1. Any portion of the premiums or benefits is paid by or on behalf of the employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium;

3. The employer has permitted payroll deduction for the covered individual or any portion of the premium is paid by the employer; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of §§ 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a health insurance issuer is in compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer in establishing premium rates for applicable insurance coverage.

"Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

1. Such period shall begin on the enrollment date.

2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in this Commonwealth, an association which:

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health

status-related factor relating to such members (or individuals eligible for coverage through a member);

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage (if any) under such COBRA continuation provision, and the waiting period (if any) and affiliation period (if applicable) imposed with respect to the individual for any coverage under such plan.

"Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (33)).

"COBRA continuation provision" means any of the following:

1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection (f) (1) of such section insofar as it relates to pediatric vaccines;

2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

3. Title XXII of P.L. 104-191.

"Community rate" means the average rate charged for the same or similar coverage to all primary small employer groups with the same area, age and gender characteristics. This rate shall be based on the health insurance issuer's combined claims experience for all groups within its primary small employer market.

"Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or B of Title ~~XVII~~ *XVIII* of the Social Security Act (U.S.C. § 1395c or § 1395);

4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

9. A public health plan (as defined in *federal* regulations); or

10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of thirty or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee.

"Eligible individual" means such an individual in relation to the employer as shall be determined:

1. In accordance with the terms of such plan;

2. As provided by the health insurance issuer under rules of the health insurance issuer which are uniformly applicable to employers in the group market; and

In accordance with all applicable law of this Commonwealth governing such issuer and such market.

"Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

"Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or more employees.

"Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection C of this section.

~~"Established geographic service area" means a broad geographic area of the Commonwealth in which a health insurance issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.~~

"Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

1. Benefits not subject to requirements of this article:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Benefits not subject to requirements of this article if offered separately:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

c. Such other similar, limited benefits as are specified in regulations.

3. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

4. Benefits not subject to requirements of this article if offered as separate insurance policy:

a. Medicare supplemental health insurance (as defined under section 1882 (g) (1) of the Social Security Act (42 U.S.C. § 1395ss (g) (1));

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

c. Similar supplemental coverage provided to coverage under a group health plan.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

"Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

"Group health insurance coverage" means in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. 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 coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in this Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within the meaning of section 514 (b) (2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b) (2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

2. An organization recognized under the laws of this Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of this Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. Individual health insurance coverage does not include short-term limited duration coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer or through a health insurance issuer.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

1. The first period in which the individual is eligible to enroll under the plan; or

2. A special enrollment period as required pursuant to subsections J through M of §38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. ~~Amounts paid for~~ Transportation primarily for and essential to medical care referred to in subdivision 1; and

3. ~~Amounts paid for~~ Insurance covering medical care referred to in subdivisions 1 and 2.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the health insurance issuer.

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (7)).

"Placed for adoption," or "placement" or "being placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"Plan sponsor" has the meaning given such term under section 3(16) (B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16) (B)).

"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.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from a health insurance issuer, including fees and other contributions associated with the health benefit plan.

"Primary small employer," a subset of "small employer," means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed no more than twenty-five eligible employees and not less than two unrelated eligible employees, except as provided in subdivision A 2 of §38.2-3523, the majority of whom are

enrolled within this Commonwealth. Primary small employer includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a primary small employer shall apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this subsection.

"Rating period" means the twelve-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

"Service area" means a broad geographic area of the Commonwealth in which a health insurance issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Small employer" means in connection with a group health plan *or health insurance coverage* with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer or through a health insurance issuer.

"State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. *If an employee or dependent enrolls during a special enrollment period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such enrollment is not a waiting period.*

C. The Commission shall adopt regulations establishing the essential and standard plans for sale in the small employer market. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. The Commission shall modify such regulations as necessary to incorporate any revisions to the essential and standard plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits pursuant to §9-298. Every health insurance issuer shall, as a condition of transacting business in Virginia with small employers, offer to small employers the essential and standard plans, *subject to the provisions of § 38.2-3432.2* . However, any regulation adopted by the Commission shall contain a provision requiring all health insurance issuers to offer an option permitting a small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title. All health insurance issuers shall issue the plans to every small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and shall satisfy the following provisions:

1. Such plan may include cost containment 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 and 38.2-4209 and Chapter 43 (§38.2-4300 et seq.) of this title; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, if a health maintenance organization is federally qualified, and of nonfederally qualified health maintenance organizations, if a health maintenance organization is not federally qualified. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for health insurance issuers.

2. No law requiring the coverage or offering of coverage of a benefit shall apply to the essential or standard health care plan or riders thereof.

3. Every health insurance issuer offering group health insurance coverage shall, as a condition of transacting business in Virginia with small employers, offer and make available to small employers an essential and a standard health benefit plan, *subject to the provisions of § 38.2-3432.2* .

4. All essential and standard benefit plans issued to small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy or plan provided that no rider, separate

policy or plan shall reduce benefit or premium. A health insurance issuer 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. Each rider, separate policy or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a health insurance issuer, disapprove the continued use by the health insurance issuer of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

5. No health insurance issuer offering group health insurance coverage is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection:

a. From a small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a health insurance issuer offering group health insurance coverage from issuing coverage to a group prior to its anniversary date; or

b. If the Commission determines that acceptance of an application or applications would result in the health insurance issuer being declared an impaired insurer.

A health insurance issuer offering group health insurance coverage that does not offer coverage pursuant to subdivision 5 b may not offer coverage to small employers until the Commission determines that the health insurance issuer is no longer impaired.

6. Every health insurance issuer offering group health insurance coverage shall uniformly apply the provisions of subdivision C 5 of this section and shall fairly market the essential and standard health benefit plans to all small employers in their ~~established geographic~~ service area of the Commonwealth. A health insurance issuer offering group health insurance coverage that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the health insurance issuer submits and the Commission approves a plan to fairly market to the health insurance issuer's ~~established geographic~~ service area.

7. No health maintenance organization is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection in the case of any of the following:

a. To small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;

b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas;

c. To small employers if the health maintenance organization is a federally qualified health maintenance organization and it demonstrates to the satisfaction of the Commission that the federally qualified health maintenance organization is prevented from doing so by federal requirement; however, any such exemption under this subdivision would be limited to the essential plan; or

d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than fifty eligible employees until the later of 180 days after closure to new applications or the date on which the health maintenance organization notifies the Commission that it has regained capacity to deliver services to small employers. In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 6 of this subsection apply.

8. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for health insurance issuers, agents and third-party administrators, including requirements relating to the following:

a. Registration by each health insurance issuer offering group health insurance coverage with the Commission of its intention to offer health insurance coverage in the small group market under this article;

b. Publication by the Commission of a list of all health insurance issuers who offer coverage in the small group market, including a potential requirement applicable to agents, third-party administrators, and health insurance issuers that no health benefit plan may be sold to a small employer by a health insurance issuer not so identified as a health insurance issuer in the small group market;

c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers to information concerning this article;

d. To the extent deemed to be necessary to ensure the fair distribution of small employers among carriers, periodic reports by health insurance issuers about plans issued to small employers; provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to primary small employers. Health insurance issuers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and

e. Methods concerning periodic demonstration by health insurance issuers offering group health insurance coverage that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

9. All essential and standard health benefits plans contracts delivered, issued for delivery, reissued, renewed, or extended in this Commonwealth on or after July 1, 1997, shall include coverage for 365 days of inpatient hospitalization for each covered individual during a twelve-month period. If coverage under the essential or standard health benefits plan terminates while a covered person is hospitalized, the inpatient hospital benefits shall continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided or (ii) the day the covered person is no longer hospitalized as an inpatient.

§38.2-3432.1. Renewability.

A. Every health insurance issuer that offers health insurance coverage in the group market in this Commonwealth shall renew or continue in force such coverage with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, or contract holder, or where the health insurance issuer has not received timely premium payments;

2. When the health insurance issuer is ceasing to offer coverage in the small group market in accordance with subdivisions 9 and 10;

3. For fraud or misrepresentation by the employer, with respect to their coverage;

4. With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission;

7. When a health insurance issuer offers health insurance coverage in the group market through a network plan, and there is no longer an enrollee in connection with such plan who lives, resides, or works in the service area of the health insurance issuer (or in the area for which the health insurance issuer is authorized to do business) and, in the case of the group market, the health insurance issuer would deny enrollment with respect to such plan under the provisions of subdivision 9 or 10;

8. When health insurance coverage is made available in the group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this subdivision uniformly without regard to any health status related factor relating to any covered individual;

9. When a health insurance issuer decides to discontinue offering a particular type of group health insurance coverage in the group market in this Commonwealth, coverage of such type may be discontinued by the health insurance issuer in accordance with the laws of this Commonwealth in such market only if (i) the health insurance issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage; (ii) the health insurance issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in such market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under this subdivision, the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related

factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

10. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the group market in this Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only in accordance with the laws of this Commonwealth and if: (i) the health insurance issuer provides notice to the Commission and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and (ii) all health insurance issued or delivered for issuance in this Commonwealth in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed;

11. In the case of a discontinuation under subdivision ~~9~~ *10* of this subsection in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market and this Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed;

12. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan or health insurance issuer offering group health insurance coverage in the group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with the laws of this Commonwealth and effective on a uniform basis among group health plans or health insurance issuers offering group health insurance coverage with that product;

13. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer; or

14. Benefits and premiums which have been added by rider to the essential or standard benefit plans issued to small employers shall be renewable at the sole option of the health insurance issuer.

B. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

§38.2-3432.2. Availability.

A. If coverage is offered under this article, ~~such coverage shall be offered and made available to all the eligible employees of every small employer and their dependents that apply for such coverage. No coverage may be offered to only certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status.~~ *in the small employer market:*

1. Such coverage shall be offered and made available to all the eligible employees of every small employer and their dependents, including late enrollees, that apply for such coverage. No coverage may be offered only to certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status; and

2. All products that are approved for sale in the small group market that the health insurance issuer is actively marketing must be offered to all small employers, and the health insurance issuer must accept any employer that applies for any of those products.

B. No coverage offered under this article shall exclude an employer based solely on the nature of the employer's business.

C. A health insurance issuer that offers health insurance coverage in a small group market through a network plan may:

1. Limit the employers that may apply for such coverage to those eligible individuals who live, work or reside in the service area for such network plan; and

2. Within the service area of such plan, deny such coverage to such employers if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

a. It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

b. It is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factors relating to such employees and dependents.

3. A health insurance issuer upon denying health insurance coverage in any service area in accordance with subdivision D 1, may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

D. A health insurance issuer may deny health insurance coverage in the small group market if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

1. It does not have the financial reserves necessary to underwrite additional coverage; and

2. It is applying this subdivision uniformly to all employers in the small group market in the Commonwealth consistent with the laws of this Commonwealth and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

E. A health insurance issuer upon denying health insurance coverage ~~in connection with group health plans~~ in accordance with subsection D in the Commonwealth may not offer coverage ~~in connection with group health plans~~ in the small group market for a period of 180 days after the date such coverage is denied or until the health insurance issuer has demonstrated to the satisfaction of the Commission that the health insurance issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

F. Nothing in this article shall be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules in connection with a health benefit plan offered in the small group market. As used in this article, the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of eligible individuals and the term "group participation rule" means a requirement relating to the minimum number of eligible employees that must be enrolled in relation to a specified percentage or number of eligible employees. Any employer contribution rule or group participation rule shall be applied uniformly among small employers without reference to the size of the small employer group, health status of the small employer group, or other factors.

§38.2-3432.3. Limitation on preexisting condition exclusion period.

A. Subject to subsection B, a health insurer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting limitation only if:

1. Such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the ~~6~~ *six* -month period ending on the enrollment date;

2. Such exclusion extends for a period of not more than twelve months (or eighteen months in the case of a late enrollee) after the enrollment date; and

3. The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

B. Exceptions:

1. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

2. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

3. A health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition; and

4. Subdivisions 1 and 2 of this subsection shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

C. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit

plan, if, after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage.

D. For purposes of subdivision B 4 and subsection C, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period under subsection C.

E. Methods of crediting coverage:

1. Except as otherwise provided under subdivision 2 of this subsection, a health insurance issuer offering group health coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period;

2. A health insurance issuer offering group health insurance coverage, may elect to count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits rather than as provided under subdivision 1 of this subsection. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category;

3. In the case of an election with respect to a group plan under subdivision 2 of this subsection (whether or not health insurance coverage is provided in connection with such plan), the plan shall: (i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and (ii) include in such statements a description of the effect of this election; and

4. In the case of an election under subdivision 2 of this subsection with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall: (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election; and (ii) include in such statements a description of the effect of such election.

F. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection G or in such other manner as may be specified in federal regulations.

G. A health insurance issuer offering group health insurance coverage, shall provide for certification of the period of creditable coverage:

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

2. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under such provision; and

3. At the request, or on behalf of, an individual made not later than twenty-four months after the date of cessation of the coverage described in subdivision 1 or 2 of this subsection, whichever is later. The certification under subdivision 1 of this subsection may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

H. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

I. In the case of an election described in subdivision E 2 by a health insurance issuer, if the health insurance issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subsection F:

1. Upon request of such health insurance issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting group insurance issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

2. Such entity may charge the requesting health insurance issuer for the reasonable cost of disclosing such information.

J. A health insurance issuer offering group health insurance coverage, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage ~~as a late enrollee for coverage~~ under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time;

3. The employee's or dependent's coverage described in subdivision 1 of this subsection: (i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated; and

4. Under the terms of the plan, the employee requests such enrollment not later than thirty days after the date of exhaustion of coverage described in subdivision 3 (i) of this subsection or termination of coverage or employer contribution described in subdivision 3 (ii) of this subsection.

K. If: (i) a health insurance issuer makes coverage available with respect to a dependent of an individual; (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and (iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer shall provide for a dependent special enrollment period described in ~~subdivision J 2~~ *subsection L* of this subsection during which the person (or, if not otherwise enrolled, the individual) may also be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

L. A dependent special enrollment period under this subsection shall be a period of not less than thirty days and shall begin on the later of:

1. The date dependent coverage is made available; or

2. The date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in ~~subdivision J 3~~ *subsection K* .

M. If an individual seeks to enroll a dependent during the first ~~30~~ *thirty* days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

2. In the case of a dependent's birth, as of the date of such birth; or

3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

N. A late enrollee may be excluded from coverage for up to eighteen months or may have a preexisting condition limitation apply for up to eighteen months; however, in no case shall a late enrollee be excluded from some or all coverage for more than eighteen months. An eligible employee or dependent shall not be considered a late enrollee if all of the conditions set forth below in subdivisions 1 through 4 are met or one of the conditions set forth below in subdivision 5 or 6 is met:

1. The individual was covered under a public or private health benefit plan at the time the individual was eligible to enroll.

2. The individual certified at the time of initial enrollment that coverage under another health benefit plan was the reason for declining enrollment.

3. The individual has lost coverage under a public or private health benefit plan as a result of termination of employment or employment status eligibility, the termination of the other plan's entire group coverage, death of a spouse, or divorce.

4. The individual requests enrollment within thirty days after termination of coverage provided under a public or private health benefit plan.

5. The individual is employed by a small employer that offers multiple health benefit plans and the individual elects a

different plan offered by that small employer during an open enrollment period.

6. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan, the minor is eligible for coverage and is a dependent, and the request for enrollment is made within thirty days after issuance of such court order.

However, such individual may be considered a late enrollee for benefit riders or enhanced coverage levels not covered under the enrollee's prior plan.

§38.2-3435. Exclusions.

The provisions of this article shall not apply to:

~~A.~~ *1* . Any health insurance issuer offering group health insurance coverage for any plan year if, on the first day of such plan year, such plan has less than two participants who are current employees~~.~~; *or*

~~B. Any nonfederal governmental plan which is a group health plan who elects not to be bound by these requirements. The election shall apply: (i) for a single specified plan year; or (ii) in the case of a plan provided pursuant to collective bargaining agreement for the term of such agreement.~~

~~1. An election under this subsection may be extended through subsequent elections.~~

2. ~~Under such an election, the plan shall provide for: (i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the act and consequences of such election and (ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with subsections G and H of §38.2-3432.3.~~

~~C.~~ Any health insurance issuer offering group health insurance coverage for any of the excepted benefits.

§38.2-3514.2. Renewability of coverage.

A. Every individual policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth providing benefits to or on behalf of an individual shall provide for the renewability of such coverage at the sole option of the insured, policyholder, subscriber, or enrollee. The insurer, health services plan or health maintenance organization issuing such policy, subscription contract or plan shall be permitted to refuse to renew the policy, subscription contract or plan only for one or more of the following reasons:

1. Nonpayment of the required premiums by the insured, policyholder, subscriber, or enrollee, or such individual's representative;

2. In the event that the policy, subscription contract or plan contains a provision requiring the use of network providers, a documented pattern of abuse or misuse of such provision by the insured, policyholder, subscriber, or enrollee, continuing for a period of no less than two years;

3. Subject to the time limits contained in subdivision 2 of §38.2-3503 or in regulations adopted by the Commission governing the practices of health maintenance organizations, for fraud or material misrepresentation by the individual, with respect to his application for coverage;

4. Eligibility of an individual insured for Medicare, provided that such coverage may not terminate with respect to other individuals insured under the same policy, subscription contract or plan and who are not eligible for Medicare; and

5. The insured, subscriber, or enrollee has not maintained a legal residence in the service area of the insurer, health services plan or health maintenance organization for a period of at least six months.

B. This section shall not apply to the following insurance policies, subscription contracts or plans:

1. Short-term travel;

2. Accident-only;

3. Disability income;

4. Limited or specified disease contracts;

5. Long-term care insurance; ~~and~~

6. Short-term nonrenewable policies or contracts of not more than six months' duration which are subject to no medical underwriting or minimal underwriting.; *and*

7. Individual health insurance coverage as defined in subsection B of § 38.2-3431 .

§38.2-3531. Additional exclusions and limitations.

A. Each group accident and sickness insurance policy shall contain a provision specifying all additional exclusions or limitations applicable under the policy for any disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy.

B. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. The exclusion or limitation shall not apply to loss incurred or disability commencing after the earlier of (i) the end of a continuous period of twelve months commencing on or after the effective date of the person's coverage during which the person receives no medical advice or treatment in connection with the disease or physical condition, or (ii) the end of the two-year period commencing on the effective date of the person's coverage.

C. This section shall not apply to group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis to an employer's employees and their dependents.

CHAPTER 25

An Act to amend the Code of Virginia by adding a section numbered 38.2-3430.3:1, relating to individual health insurance; guaranteed availability.

[H 782]
Approved March 9, 1998

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.2-3430.3:1 as follows:

§ 38.2-3430.3:1. Guaranteed availability of individual health insurance coverage to certain individuals with prior group or individual coverage.

A. 1. All individuals who qualified to meet the definition of "eligible individual" as set forth in § 38.2-3430.2 between April 29, 1997, and January 1, 1998, and are currently neither eligible for nor enrolled in (i) a group health plan which would provide coverage for preexisting conditions or (ii) Part A or Part B of Title XVIII of the Social Security Act, shall be provided a choice of all individual health insurance coverage being offered by a health insurance issuer, and the chosen coverage shall be issued, regardless of whether they have obtained individual coverage during this period of time provided the existing individual coverage is replaced with new coverage.

2. Such coverage provided as required in subdivision A 1 shall not impose any preexisting condition exclusion with respect to such coverage.

B. Health insurance issuers are prohibited from imposing any limitations or exclusions based upon named conditions that apply to eligible individuals.

2. That an emergency exists and this act is in force from its passage.

3. That the provisions of this act shall expire on January 1, 1999.

CHAPTER 26

An Act to amend and reenact §§ 38.2-3431 and 38.2-3433 of the Code of Virginia, relating to accident and sickness insurance; small employer market.

[H 854]
Approved March 9, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§38.2-3431 and 38.2-3433 of the Code of Virginia are amended and reenacted as follows:

§38.2-3431. Application of article; definitions.

A. This article applies to group health plans and to health insurance issuers offering group health insurance coverage, and individual policies offered to employees of small employers.

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in this Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium;

3. The employer has permitted payroll deduction for the covered individual or any portion of the premium is paid by the employer; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of §§ 106, 125, or § 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a health insurance issuer is in compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer in establishing premium rates for applicable insurance coverage.

"Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

1. Such period shall begin on the enrollment date.

2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in this Commonwealth, an association which:

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an

employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage (if any) under such COBRA continuation provision, and the waiting period (if any) and affiliation period (if applicable) imposed with respect to the individual for any coverage under such plan.

"Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (33)).

"COBRA continuation provision" means any of the following:

1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection (f) (1) of such section insofar as it relates to pediatric vaccines;

2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

3. Title XXII of P.L. 104-191.

"Community rate" means the average rate charged for the same or similar coverage to all ~~primary~~ small employer groups with the same area, age and gender characteristics. This rate shall be based on the health insurance issuer's combined claims experience for all groups within its ~~primary~~ small employer market.

"Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or B of Title XVII of the Social Security Act (U.S.C. § 1395c or § 1395);

4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

9. A public health plan (as defined in regulations); or

10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of thirty or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee.

"Eligible individual" means such an individual in relation to the employer as shall be determined:

1. In accordance with the terms of such plan;

2. As provided by the health insurance issuer under rules of the health insurance issuer which are uniformly applicable to employers in the group market; and

3. In accordance with all applicable law of this Commonwealth governing such issuer and such market.

"Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

"Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or more employees.

"Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection C of this section.

"Established geographic service area" means a broad geographic area of the Commonwealth in which a health insurance issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

1. Benefits not subject to requirements of this article:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Benefits not subject to requirements of this article if offered separately:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

c. Such other similar, limited benefits as are specified in regulations.

3. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

4. Benefits not subject to requirements of this article if offered as separate insurance policy:

a. Medicare supplemental health insurance (as defined under section 1882 (g) (1) of the Social Security Act (42 U.S.C. § 1395ss (g) (1));

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

c. Similar supplemental coverage provided to coverage under a group health plan.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

"Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

"Group health insurance coverage" means in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. 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 coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in this Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within the meaning of section 514 (b) (2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b) (2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

2. An organization recognized under the laws of this Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of this Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. Individual health insurance coverage does not include short-term limited duration coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer or through a health insurance issuer.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

1. The first period in which the individual is eligible to enroll under the plan; or

2. A special enrollment period as required pursuant to subsections J through M of §38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. Amounts paid for transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Amounts paid for insurance covering medical care referred to in subdivisions 1 and 2.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the health insurance issuer.

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (7)).

"Placed for adoption," or "placement" or "being placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"Plan sponsor" has the meaning given such term under section 3(16) (B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16) (B)).

"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.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from a health insurance issuer, including fees and other contributions associated with the health benefit plan.

~~"Primary small employer," a subset of "small employer," means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed no more than twenty-five eligible employees and not less than two unrelated eligible employees, except as provided in subdivision A 2 of §38.2-3523, the majority of whom are enrolled within this Commonwealth. Primary small employer includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a primary small employer shall apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this subsection.~~

"Rating period" means the twelve-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

"Small employer" means in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer or through a health insurance issuer.

"State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

C. The Commission shall adopt regulations establishing the essential and standard plans for sale in the small employer market. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. The Commission shall modify such regulations as necessary to incorporate any revisions to the essential and standard plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits pursuant to §9-298. Every health insurance issuer shall, as a condition of transacting business in Virginia with small employers, offer to small employers the essential and standard plans. However, any regulation adopted by the Commission shall contain a provision requiring all health insurance issuers to offer an option permitting a small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title. All health insurance issuers shall issue the plans to every small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and shall satisfy the following provisions:

1. Such plan may include cost containment 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 and 38.2-4209 and Chapter 43 (§38.2-4300 et seq.) of this title; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, if a health maintenance organization is federally qualified, and of nonfederally qualified health maintenance organizations, if a health maintenance organization is not federally qualified. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for health insurance issuers.

2. No law requiring the coverage or offering of coverage of a benefit shall apply to the essential or standard health care plan or riders thereof.

3. Every health insurance issuer offering group health insurance coverage shall, as a condition of transacting business in Virginia with small employers, offer and make available to small employers an essential and a standard health benefit plan.

4. All essential and standard benefit plans issued to small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium. A health insurance issuer 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. Each

rider, separate policy or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a health insurance issuer, disapprove the continued use by the health insurance issuer of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

5. No health insurance issuer offering group health insurance coverage is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection:

a. From a small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a health insurance issuer offering group health insurance coverage from issuing coverage to a group prior to its anniversary date; or

b. If the Commission determines that acceptance of an application or applications would result in the health insurance issuer being declared an impaired insurer.

A health insurance issuer offering group health insurance coverage that does not offer coverage pursuant to subdivision 5 b may not offer coverage to small employers until the Commission determines that the health insurance issuer is no longer impaired.

6. Every health insurance issuer offering group health insurance coverage shall uniformly apply the provisions of subdivision C 5 of this section and shall fairly market the essential and standard health benefit plans to all small employers in their established geographic service area of the Commonwealth. A health insurance issuer offering group health insurance coverage that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the health insurance issuer submits and the Commission approves a plan to fairly market to the health insurance issuer's established geographic service area.

7. No health maintenance organization is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection in the case of any of the following:

a. To small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;

b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas;

c. To small employers if the health maintenance organization is a federally qualified health maintenance organization and it demonstrates to the satisfaction of the Commission that the federally qualified health maintenance organization is prevented from doing so by federal requirement; however, any such exemption under this subdivision would be limited to the essential plan; or

d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than fifty eligible employees until the later of 180 days after closure to new applications or the date on which the health maintenance organization notifies the Commission that it has regained capacity to deliver services to small employers. In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 6 of this subsection apply.

8. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for health insurance issuers, agents and third-party administrators, including requirements relating to the following:

a. Registration by each health insurance issuer offering group health insurance coverage with the Commission of its intention to offer health insurance coverage in the small group market under this article;

b. Publication by the Commission of a list of all health insurance issuers who offer coverage in the small group market, including a potential requirement applicable to agents, third-party administrators, and health insurance issuers that no health benefit plan may be sold to a small employer by a health insurance issuer not so identified as a health insurance issuer in the

small group market;

c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers to information concerning this article;

'. To the extent deemed to be necessary to ensure the fair distribution of small employers among carriers, periodic reports by ealth insurance issuers about plans issued to small employers; provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to ~~primary~~ small employers. Health insurance issuers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and

e. Methods concerning periodic demonstration by health insurance issuers offering group health insurance coverage that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

9. All essential and standard health benefits plans contracts delivered, issued for delivery, reissued, renewed, or extended in this Commonwealth on or after July 1, 1997, shall include coverage for 365 days of inpatient hospitalization for each covered individual during a twelve-month period. If coverage under the essential or standard health benefits plan terminates while a covered person is hospitalized, the inpatient hospital benefits shall continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided or (ii) the day the covered person is no longer hospitalized as an inpatient.

§38.2-3433. Small employer market premium and disclosure provisions.

A. New or renewal premium rates for essential or standard health benefit plans issued by a health insurance issuer to a ~~primary~~ small employer not currently enrolled with that same health insurance issuer shall be based on a community rate subject to the following conditions:

1. A health insurance issuer may use the following risk classification factors in rating small groups: demographic rating, including age and gender; and geographic area rating. A health insurance issuer may not use claim experience, health status, duration or other risk classification factors in rating such groups, except as provided in subdivision 2 of this subsection.

2. The premium rates charged by a health insurance issuer may deviate from the community rate filed by the health insurance issuer by not more than twenty percent above or twenty percent below such rate for claim experience, health status and duration only during a rating period for such groups within a similar demographic risk classification for the same or similar coverage. Rates for a health benefit plan may vary based on the number of the eligible employee's enrolled dependents.

. Health insurance issuers shall apply rating factors consistently with respect to all ~~primary~~ small employers in a similar demographic risk classification. Adjustments in rates for claims experience, health status and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the ~~primary~~ small employer.

B. In connection with the offering for sale of any health benefit plan to a ~~primary~~ small employer, each health insurance issuer shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

1. The extent to which premium rates for a specific ~~primary~~ small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of such ~~primary~~ small employer;

2. Provisions relating to renewability of policies and contracts; and

3. Provisions affecting any preexisting conditions provision.

C. Each health insurance issuer shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices pertaining to its ~~primary~~ small employer business, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

D. Each health insurance issuer shall file with the Commission annually on or before March 15 the community rates and an actuarial certification certifying that the health insurance issuer and its rates are in compliance with this article. A copy of such certification shall be retained by the health insurance issuer at its principal place of business.

E. A health insurance issuer shall make the information and documentation described in subsection C of this section available for review by the Commission upon request.

CHAPTER 154

An Act to amend and reenact §§ 38.2-3323, 38.2-3324, 38.2-3331, 38.2-3525, 38.2-3526, 38.2-3533, 38.2-3543.1, 38.2-4214 and 38.2-4319 of the Code of Virginia; to amend the Code of Virginia by adding sections numbered 38.2-3318.1 through 38.2-3322.2, 38.2-3521.1 through 38.2-3523.4, and 38.2-3543.2; and to repeal §§ 38.2-3318 through 38.2-3322 and 38.2-3521 through 38.2-3524 of the Code of Virginia, relating to group life and group accident and sickness insurance policies; delivery requirements.

[H 855]
Approved March 16, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§38.2-3323, 38.2-3324, 38.2-3331, 38.2-3525, 38.2-3526, 38.2-3533, 38.2-3543.1, 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.2-3318.1 through 38.2-3322.2, 38.2-3521.1 through 38.2-3524.4, and 38.2-3543.2 as follows:

§ 38.2-3318.1 . Group life insurance requirements.

Except as provided in § 38.2-3319.1 , no policy of group life insurance shall be delivered in this Commonwealth unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" include:

a. The employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships, or partnerships is under common control;

b. The individual proprietor or partners if the employer is an individual proprietorship or partnership;

c. Retired employees, former employees and directors of a corporate employer; or

d. If the policy is issued to insure the employees of a public body, elected or appointed officials.

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

B. A policy which is:

1. Not subject to Chapter 37.1 (§ 38.2-3727 et seq.) of this title, and

2. Issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor, or creditors, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" includes:

(1) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(2) The debtors of one or more subsidiary corporations; and

(3) The debtors of one or more affiliated corporations, proprietorships, or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships, or partnerships is under common control.

b. The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The amount of the insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor.

5. The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment and any excess of the insurance shall be payable to the estate of the insured.

6. Notwithstanding the provisions of the above subsections, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

C. A policy issued to a labor union, or similar employee organization, which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

1. The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

2. The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

D. A policy issued to or for (i) a multiple employer welfare arrangement, a rural electric cooperative, or a rural electric telephone cooperative as these terms are defined in 29 U.S.C. § 1002, or (ii) a trust or to the trustees of a fund established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employees or the unions or organizations, subject to the following requirements:

1. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term employees includes:

a. The employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control:

b. The individual proprietor or partners if the employer is an individual proprietorship or partnership;

c. Retired employees, former employees and directors of a corporate employer; or

d. The trustees or their employees, or both, if their duties are principally connected with such trusteeship.

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

E. 1. A policy issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall:

a. Have at the outset a minimum of 100 persons;

b. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;

c. Have been in active existence for at least five years; and

d. Have a constitution and bylaws which provide that: (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees.

2. The policy shall be subject to the following requirements:

a. The policy may insure members of such association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

c. Except as provided in clause d of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

d. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

F. A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees, or agent shall be deemed policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

1. The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

2. The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision 3 of this subsection, must insure all eligible members.

3. An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

G. A policy issued to an incorporated association as described in § 38.2-4000, 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 other expenses. The association shall be deemed the policyholder, to insure the members of the association for the benefit of persons other than the association. The policy shall be subject to the following requirements:

1. A policy may not be issued to an association in which membership is conditioned upon the member's designation at any time of a specific funeral director or cemetery as the beneficiary under the insurance, so as to deprive the representatives or family of the deceased member from, or in any way control them in, obtaining funeral supplies and services in an open competitive market.

2. The policy shall insure members of such association.

3. The premium for the policy shall be paid from funds contributed by the association, or from funds contributed by the covered persons, or both.

4. Except as provided in subdivision 5 of this subsection, a policy on which no part of the premium is to be derived from

funds contributed by the covered persons specifically for the insurance must insure all eligible persons except those who reject the coverage in writing.

5. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

§ 38.2-3319.1 . Limits of group life insurance.-

Group life insurance offered to a resident of this Commonwealth under a group life insurance policy issued to a group other than one described in § 38.2-3318.1 shall be subject to the following requirements:

A. No such group life insurance policy shall be delivered in this Commonwealth unless the Commission finds that:

1. The issuance of such group policy is not contrary to Virginia's public policy and is in the best interest of the citizens of this Commonwealth;

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

Insurers filing policy forms seeking approval under the provisions of this subsection shall accompany the forms with a certification, signed by the officer of the company with the responsibility for forms compliance, in which the company certifies that each such policy form will be issued only where the requirements set forth in subdivisions 1 through 3 of this subsection have been met.

B. No such group life insurance coverage may be offered in this Commonwealth by an insurer under a policy issued in another state unless this Commonwealth or another state having requirements substantially similar to those contained in subdivisions 1, 2 and 3 of subsection A has made a determination that such requirements have been met.

An insurer offering group life insurance coverage in this Commonwealth under this subsection shall file a certification, signed by the officer of the company having responsibility for forms compliance in which the company certifies that all group insurance coverage marketed to residents of this Commonwealth under policies which have not been approved by this Commonwealth will comply with the provisions of § 38.2-3318.1 or have met the requirements set forth in subdivisions A 1 through A 3 of this section, and which clearly demonstrates that the substantially similar requirements of the state in which the contract will be issued have been met. The certification shall be accompanied by documentation from such state evidencing the determination that such requirements have been met.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

D. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

§ 38.2-3319.2 . Review of records.

The Commission may review the records of any insurer to determine that the insurer's policies have been issued in compliance with the requirements set forth in this article. Insurers issuing coverage not complying with the provisions of § 38.2-3318.1 and not complying with the requirements of 38.2-3319.1 shall be deemed to have committed a knowing and willful violation of this article, and shall be punished as set forth in subsection A of § 38.2-218.

§ 38.2-3320.1 . Policies issued outside of the Commonwealth of Virginia.

A group life insurance policy issued outside of this Commonwealth, providing coverage to residents of this Commonwealth, that does not qualify under § 38.2-3318.1 or does not comply with § 38.2-3319.1 shall be subject to the statutory requirements of this title and may subject the insurer issuing such policy to the penalties available under this title for violation of such requirements.

§ 38.2-3321.1 . Requirements for those marketing group life insurance.

Insurance marketed to certificate holders of a group that does not qualify pursuant to § 38.2-3318.1 must be marketed by a person holding a valid life and health insurance agent license as required by Chapter 18 (§ 38.2-1800 et seq.) of this title.

§ 38.2-3322.1 Regulations.

The Commission may issue regulations to establish standards for group life insurance pursuant to the authority provided in § 38.2-223 .

§ 38.2-3322.2 . Lives covered.

A group life insurance policy shall cover at least two persons, other than spouses or minor children, at the issue date and at each policy anniversary date.

§38.2-3323. Group life insurance coverages of spouses and minor dependent children; dependent handicapped children.

A. Coverage under a group life insurance policy, except a ~~group credit life insurance~~ policy *issued pursuant to § 38.2-3318.1 B* , may be extended to insure the spouse and any child who is under the age of nineteen years or who is a dependent and a full-time student under twenty-five years of age, or any class of spouses and dependent children, of each insured group member who so elects. The amount of insurance on the life of a spouse or child shall not exceed the amount of insurance on the life of the insured group member.

B. A spouse insured under this section shall have the same conversion right to the insurance on his or her life as the insured group member.

C. Notwithstanding the provisions of §38.2-3331, one certificate may be issued for each family unit if a statement concerning any spouse's or dependent child's coverage is included in the certificate.

D. In addition to the coverages afforded by the provisions of this section, any such plan for group life insurance which includes coverage for children shall afford coverage to any child who is both (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (ii) chiefly dependent upon the employee for support and maintenance. Upon request of the insurer, proof of incapacity and dependency shall be furnished to the insurer by the policyowner within thirty-one days of the child's attainment of the specified age. Subsequent proof may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the specified age. The insurer shall be allowed to charge a premium at the insurer's then customary rate applicable to such group policy for such extended coverage.

E. 1. Upon termination of such group coverage of a child, the child shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual life insurance policy without disability or other supplementary benefits, if:

a. An application for the individual policy is made, and the first premium paid to the insurer, within thirty-one days after such termination; and

b. The individual policy, at the option of such person, is on any one of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance;

c. The individual policy is in an amount not in excess of the amount of life insurance which ceases because of such termination, less the amount of any life insurance for which such person becomes eligible under the same or any other group policy within thirty-one days after such termination, provided that any amount of insurance which has matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

d. The premium on the individual policy is at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to the individual age attained on the effective date of the individual policy.

2. Subject to the same conditions set forth above, the conversion privilege shall be available (i) to a surviving dependent, if any, at the death of the group member, with respect to the coverage under the group policy which terminates by reason of such death, and (ii) to the dependent of the group member upon termination of coverage of the dependent, while the group member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.

§38.2-3324. Standard provisions required; exceptions.

A. No group life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it contains in substance the standard provisions prescribed in this article. The standard provisions required for individual life insurance policies shall not apply to group life insurance policies.

B. If a group life insurance policy is not term insurance, it shall contain a nonforfeiture provision that in the opinion of the Commission is equitable to the insured persons and to the policyholder. This subsection shall not be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

C. The provisions of §38.2-3330, subsection A of §38.2-3331, and §§38.2-3332 through 38.2-3334 shall not apply to ~~group credit life insurance~~ policies *issued pursuant to § 38.2-3318.1 B* or group life insurance contracts in which the insurable interest is as described in subdivision 3 of subsection B of §38.2-301.

§38.2-3331. Individual certificates.

A. Each group life insurance policy shall contain a provision that the insurer will issue to the policyholder, for delivery to each person insured, an individual certificate setting forth:

1. The insured person's insurance protection, including any limitations, reductions and exclusions applicable to the coverage provided;

2. To whom the insurance benefits are payable; and

3. The rights and conditions set forth in §§38.2-3332, 38.2-3333 and 38.2-3334.

B. Each ~~group credit life insurance~~ policy *issued pursuant to § 38.2-3318.1 B* , where any part of the premium is paid by the debtors or by the creditor from identifiable charges collected from the insured debtors not required of an uninsured debtor, shall contain a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a form that will contain a statement that the life of the debtor is insured under the policy and that any death benefit paid under the policy by reason of his death shall be applied to reduce or extinguish the indebtedness.

§ 38.2-3521.1 . Group accident and sickness insurance definitions.

Except as provided in § 38.2-3522.1 , no policy of group accident and sickness insurance shall be delivered in this Commonwealth unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

B. A policy which is:

1. Not subject to Chapter 37.1 (§ 38.2-3727 et seq.) of this title, and

2. Issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

(1) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a

credit transaction;

(2) The debtors of one or more subsidiary corporations; and

(3) The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control.

b. The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy.

5. The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of the insurance shall be payable to the insured or the estate of the insured.

6. Notwithstanding the preceding provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

C. A policy issued to a labor union, or similar employee organization, which labor union or organization shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

1. The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

2. The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

D. A policy issued to or for (i) a multiple employer welfare arrangement, a rural electric cooperative, or a rural electric telephone cooperative as these terms are defined in 29 U.S.C. § 1002, or (ii) to a trust, or to the trustees of a fund, established or adopted by or for two or more employers, or by one or more labor unions of similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

1. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employee" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

E. 1. A policy issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations which association or trust shall be deemed the policyholder. The association or associations shall:

a. Have at the outset a minimum of 100 persons;

b. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;

c. Have been in active existence for at least five years;

d. Have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees;

e. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

f. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

g. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

h. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

2. The policy shall be subject to the following requirements:

a. The policy may insure members of such association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

3. Except as provided in subdivision 4 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

4. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

F. A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees, or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

1. The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

2. The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision 3 of this subsection, must insure all eligible members.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

G. A policy issued to a health maintenance organization as provided in subsection B of § 38.2-4314 .

§ 38.2-3522.1 . Limits of group accident and sickness insurance.

Group accident and sickness insurance offered to a resident of this Commonwealth under a group accident and sickness insurance policy issued to a group other than one described in § 38.2-3521.1 shall be subject to the following requirements:

A. No such group accident and sickness insurance policy shall be delivered in this Commonwealth unless the Commission finds that:

1. The issuance of such group policy is not contrary to Virginia's public policy and is in the best interest of the citizens of this Commonwealth;

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

Insurers filing policy forms seeking approval under the provisions of this subsection shall accompany the forms with a certification, signed by the officer of the company with the responsibility for forms compliance, in which the company certifies that each such policy form will be issued only where the requirements set forth in subdivisions 1 through 3 of this subsection have been met.

B. No such group accident and sickness insurance coverage may be offered in this Commonwealth by an insurer under a policy issued in another state unless this Commonwealth or another state having requirements substantially similar to those contained in subdivisions 1, 2, and 3 of subsection A has made a determination that such requirements have been met.

1. An insurer offering group accident and sickness insurance coverage in this Commonwealth under this subsection shall file a certification, signed by the officer of the company having responsibility for forms compliance in which the company certifies that all group insurance coverage marketed to residents of this Commonwealth under policies which have not been approved by this Commonwealth will comply with the provisions of § 38.2-3521.1 or have met the requirements set forth in subdivisions A 1 through A 3 of this section, and which clearly demonstrates that the substantially similar requirements of the state in which the contract will be issued have been met. The certification shall be accompanied by documentation from such state, evidencing the determination that such requirements have been met.

2. An insurer offering group accident and sickness insurance in this Commonwealth under this subsection that is unable to provide the documentation required in subdivision 1 of this subsection shall be required to file policy forms consistent with requirements in § 38.2-316 which are imposed on policies issued in Virginia. The policy shall be required to be approved as meeting all requirements of this title prior to its being offered to residents of this Commonwealth.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

D. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

§ 38.2-3523.1 . Review of records.

The Commission may review the records of any insurer to determine that the insurer's policies have been issued in compliance with the requirements set forth in this article. Insurers issuing coverage not complying with the provisions of § 38.2-3521.1 and not complying with the provisions of § 38.2-3522.1 shall be deemed to have committed a knowing and willful violation of this article, and shall be punished as set forth in subsection A of § 38.2-218 .

§ 38.2-3523.2 . Policies issued outside of the Commonwealth of Virginia.

A group accident and sickness insurance policy issued outside of this Commonwealth, providing coverage to residents of this Commonwealth, that does not qualify under § 38.2-3521.1 or § 38.2-3522.1 shall be subject to the statutory requirements of this title and may subject the insurer issuing such policy to the penalties available under this title for violation of such requirements.

§ 38.2-3523.3 . Requirements for those marketing group accident and sickness insurance.

Insurance marketed to certificate holders of a group which does not qualify under § 38.2-3521.1 or § 38.2-3522.1 must be marketed by a person holding a valid life and health insurance agent or health agent license as required by Chapter 18 (§ 38.2-1800 et seq.) of this title.

§ 38.2-3523.4 . Minimum number of persons covered.

A group accident and sickness insurance policy shall on the issue date and at each policy anniversary date, cover at least two persons, other than spouses or minor children, unless such spouse or minor child is determined to be an eligible employee as defined in § 38.2-3431 .

.2-3525. Group accident and sickness insurance coverages of spouses or dependent children.

A. Coverage under a group accident and sickness insurance policy, except a ~~group credit accident and sickness insurance policy.~~ *policy issued pursuant to § 38.2-3521.1 B,* may be extended to insure the spouse and any child who is under the age of nineteen years or who is a dependent and a full-time student under twenty-five years of age, without regard to whether such child resides in the same household as the certificate holder, or any class of spouse and dependent children, of each insured group member who so elects. The amount of accident and sickness insurance for the spouse or dependent child shall not exceed the amount of accident and sickness insurance for the insured group member.

B. Notwithstanding the provisions of §38.2-3538, one certificate may be issued for each family unit if a statement concerning any spouse's or dependent child's coverage is included in the certificate.

§38.2-3526. Standard provisions required; exceptions.

A. No group accident and sickness insurance policy shall be delivered or issued for delivery in this Commonwealth unless it contains the standard provisions prescribed in this article.

B. The provisions of §38.2-3531, subsection A of §§38.2-3533 and 38.2-3538 shall not apply to ~~group credit accident and sickness insurance~~ policies *issued pursuant to § 38.2-3522.1 B* .

§38.2-3533. Individual certificates.

A. Each group accident and sickness insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth:

1. The insured person's insurance protection, including any limitations, reductions, and exclusions applicable to the coverage provided;

2. To whom the insurance benefits are payable;

3. Any family member's or dependent's coverage; and

4. The rights and conditions set forth in §38.2-3541.

B. Each group ~~credit accident and sickness~~ policy *issued pursuant to § 38.2-3522.1 B* , where any part of the premium is paid by debtors from identifiable charges collected from the insured debtors not required of an uninsured debtor, shall contain a provision that the insurer will furnish to the policyholder for each debtor insured under the policy a form that will contain a statement describing the debtor's coverage and that the benefits payable shall be applied to reduce or extinguish the indebtedness.

§38.2-3543.1. Regulations.

The Commission may establish rules and regulations for coordination of benefits~~.~~ *, as well as to establish standards to be met in connection with the marketing and contracting for group accident and sickness insurance in this Commonwealth.* Pursuant to the authority granted by §38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to establish standards with regard to coordination of benefits provisions.

§ 38.2-3543.2 . Applicability of laws.

In the event of conflict between the provisions of this article and other provisions of this title, the provisions of this article shall be controlling.

§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, 38.2-210 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, 38.2-1317 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, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 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, 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*, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 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, Chapter 9 (§38.2-900 et seq.) of this title, *§§* 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§38.2-1317 et seq.) of Chapter 13, §§38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, *38.2-3522.1 through 38.2-3523.4*, 38.2-3525, 38.2-3542, *38.2-3543.2*, Chapter 53 (§38.2-5300 et seq.) and Chapter 54 (§38.2-5400 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in §38.2-3431, a health maintenance organization providing health care plans pursuant to §38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

2. That §§38.2-3318 through 38.2-3322 and 38.2-3521 through 38.2-3524 of the Code of Virginia are repealed.

VIRGINIA ACTS OF ASSEMBLY -- CHAPTER

An Act to amend and reenact §§ 32.1-325, 32.1-351, and 32.1-352 of the Code of Virginia and to repeal § 32.1-353 of the Code of Virginia, relating to Virginia Children's Medical Security Insurance Plan.

[H 1074]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§32.1-325, 32.1-351, and 32.1-352 of the Code of Virginia are amended and reenacted as follows:

§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 twenty-one, 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 $2,500 for the individual and an amount not in excess of $2,500 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 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 twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one 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 payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma or breast cancer 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. Regulations to implement this provision shall be effective in 280 days or less of the enactment of this subdivision. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process; ~~and~~

8. A provision to provide coverage to children up to the age of nineteen in compliance with the requirements of Title XXI of

the Social Security Act, as amended, and the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP) as established in Subtitle J of the federal Balanced Budget Act of 1997 (P.L. 105-33). This program shall be known as the Virginia Children's Medical Security Insurance Plan in accordance with Chapter 13 (§ 32.1-351 et seq.) of this title; and

~~8.~~ *9.* A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance.

In preparing the plan, the Board shall 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. The Board shall also initiate such cost containment or other measures as are set forth in the appropriations act. The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

The Board's regulations shall 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."

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 (§9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of §9-6.14:4.1, (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 which 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.

B. The Director of Medical Assistance Services is authorized to administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to 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.

C. The Director of Medical Assistance Services is authorized to 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.

The Director may refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony. In addition, the Director may 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.

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 (§9-6.14:1 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.

When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or 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 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. These regulations shall be effective within 280 days of July 1, 1996. The Board shall promulgate regulations for the reimbursement of licensed clinical nurse specialists to be effective

within 280 days of the enactment of this provision.

D. 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 as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen 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.

E. 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.

Except as provided in subsection I of §11-45, the provisions of the Virginia Public Procurement Act (§11-35 et seq.) shall not apply to the activities of the Director authorized by this subsection. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§32.1-351. Virginia Children's Medical Security Insurance Plan established.

A. The Department of Medical Assistance Services shall develop *and implement* the Virginia Children's Medical Security Insurance Plan to provide coverage for individuals, up to the age of ~~eighteen~~ *nineteen* , when such individuals (i) ~~are in families with~~ *have family* incomes at *or below* 200 percent of the *federal* poverty level ~~or less~~, *as set forth in the appropriation act*, and (ii) are ~~not insured or are underinsured by any policy, plan or contract providing health benefits~~ *otherwise eligible for such benefits in compliance with Title XXI of the Social Security Act, as amended, and the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP) as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33 .*

B. The Department of Medical Assistance Services shall develop ~~a proposal~~ *and submit to the federal Secretary of Health and Human Services a Title XXI plan* for this program ~~by December 1, 1997~~ *and may revise such plan as may be necessary. Such plan shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act.*

~~In developing this proposal, the Department shall consider, but need not limit its proposal to: (i) the services recommended by the American Academy of Pediatrics in its Child Health Insurance Reform Plan (CHIRP); (ii) the provision of services through a network of participating providers; (iii) the development of public/private partnerships; (iv) a schedule for providing universal coverage for uninsured and underinsured children in families with incomes at 200 percent of the poverty level or less, to be phased in over a period of five years; and (v) alternatives for soliciting or requiring contributions from employers. The Department shall also include in its proposal criteria for determining "underinsured."~~

C. Funding for this program shall be provided through *state and federal appropriations and may include appropriations of any funds which may be generated through* the Virginia Children's Medical Security Insurance Plan Trust Fund.

D. The Board of Medical Assistance Services may promulgate such regulations pursuant to the Administrative Process Act (§9-6.14:1 et seq.) as may be necessary for the implementation of the program ~~consistent with this chapter~~. *The first set of such regulations shall be promulgated by the Board to be effective within 280 days of the enactment of this provision.*

§32.1-352. Virginia Children's Medical Security Insurance Plan Trust Fund.

A. ~~For the purpose of providing primary and preventive care to certain individuals up to the age of eighteen.~~ There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Children's Medical Security Insurance Plan Trust Fund, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. The Fund shall consist of the premium differential, any employer contributions which may be solicited or received by the Department of Medical Assistance Services, and all grants, donations, gifts, and bequests from any source, public or private. As used in this section, "premium differential" means an amount equal to the difference between (i) 0.75 percent of the direct gross subscriber fee income derived from eligible contracts and (ii) the amount of license tax revenue generated pursuant to subdivision A 4 of §58.1-2501 with respect to eligible contracts. As used in this section, "eligible contract" means any subscription contract for any kind of plan classified and defined in §38.2-4201 or §38.2-4501 issued other than to (i) an individual or (ii) a primary small group employer if income from the contract is subject to license tax at the rate of 2.25 percent pursuant to subdivision D of §38.2-4229.1. The State Corporation Commission shall annually, on or before June 30, calculate the premium differential for the immediately preceding taxable year and notify the Comptroller of the Commonwealth to transfer such amount to the Virginia Children's Medical Security Insurance Plan Trust Fund as established on the books of the Comptroller.

B. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general

fund but shall remain in the Fund. Moneys in the Fund shall be used solely to support the Virginia Children's Medical Security Insurance Plan, ~~developed by the Department of Medical Assistance Services pursuant to §32.1-351. No more than five percent of such Fund may be used for administration~~ *in accordance with the requirements of Title XXI of the Social Security Act, as amended, and the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP), as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33).*

C. The Director of the Department of Medical Assistance Services shall report annually on December 1 to the Governor, the General Assembly, and the Joint Commission on Health Care on the status of the Fund, the number of children served *by this program* , the costs of such services, and any issues related to the Virginia Children's Medical Security Insurance Plan that may need to be addressed. ~~The first such report shall, however, consist of the proposal for implementation of the Virginia Children's Medical Security Insurance Plan as required by this chapter.~~

2. That §32.1-353 of the Code of Virginia is repealed.

3. That the Department of Medical Assistance Services shall submit and seek approval of a waiver from the federal Health Care Financing Administration (HCFA) to charge premiums and co-payments on a sliding scale for children whose family income is above 150 percent of the federal poverty level. Should the waiver not be approved by HCFA, the Department of Medical Assistance Services shall submit a Title XXI plan using Medicaid income methodologies and Medicaid benefits, but which charges premiums and co-payments on a sliding fee scale for children whose family income is above 150 percent of the federal poverty level.

CHAPTER 908

An Act to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.12, relating to health care coverage; point-of-service plans.

[H 1075]
Approved May 22, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.12 as follows:

§ 38.2-3407.12 . Patient optional point-of-service benefit.

A. As used in this section:

"Affiliate" shall have the meaning set forth in § 38.2-1322 .

"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;

2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services plans which are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;

3. Any health maintenance organization licensed under this title which provides or arranges for the provision of one or more health care plans which are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;

4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans which are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and

5. Any other person licensed under this title which provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels which are subject to regulation as the business of insurance under this title.

"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service which is not paid by the carrier and for which the enrollee is responsible.

"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the enrollee to the provider towards the allowable charge as a condition of the receipt of specific health care items and services.

"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the enrollee as a condition to or consequence of the receipt of covered items or services.

"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.

"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.

"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.

"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 2 (§ 2.1-11.1 et seq.) of Title 2.1 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C.

"Group specific administrative cost" means the direct administrative cost incurred by a carrier related to the offer of the point-of-service benefit to a particular group contract holder.

"Health care plan" shall have the meaning set forth in § 38.2-4300.

"Person" means any individual, corporation, trust, association, partnership, limited liability company, organization or other entity.

"Point-of-service benefit" means a health maintenance organization's delivery system or covered benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with the health maintenance organization, which permit an enrollee (and eligible dependents) to receive covered items and services outside of the provider panel, including optometrists and clinical psychologists, of the health maintenance organization under the terms and conditions of the group contract holder's group health benefit plan with the health maintenance organization or with another carrier arranged by or under contract with the health maintenance organization and which otherwise complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee (and eligible dependents) to receive the full range of covered items and services outside of a provider panel, including optometrists and clinical psychologists, and which are otherwise in compliance with applicable law and this section shall constitute a point-of-service benefit.

"Preferred provider organization plan" means a health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209 .

"Provider" means any physician, hospital or other person, including optometrists and clinical psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health care items or services.

"Provider panel" means the participating providers or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health maintenance organization or other carrier.

B. To the maximum extent permitted by applicable law, every health care plan offered or proposed to be offered in this Commonwealth by a health maintenance organization licensed under this title to a group contract holder shall provide or include, or the health maintenance organization shall arrange for or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered in conjunction with the health maintenance organization's health care plan as an additional benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every health maintenance organization shall, at no additional cost to the group contract holder, make available or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance acceptable to the Commission which accurately and completely explains to the group contract holder and prospective enrollee the point-of-service benefit and permits each enrollee to make his or her election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the carrier in any reasonable manner.

C. To the extent permitted under applicable law, a health maintenance organization providing or arranging, or contracting with another carrier to provide, the point-of-service benefit under this section and a carrier providing the point-of-service benefit required under this section under arrangement or contract with a health maintenance organization:

1. May not impose, or permit to be imposed, a minimum enrollee participation level on the point-of-service benefit alone;

2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or § 38.2-4221 for items or services provided under the point-of-service benefit required under this section solely on the basis of the license or certification of the provider to provide such items or services if the carrier otherwise covers the items or services provided and the provision of the items or services is within the provider's lawful scope of practice or authority; and

3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group prior to any enrollee electing to accept or reject the point-of-service benefit.

D. The premium imposed by a carrier with respect to enrollees who select the point-of-service benefit may be different from that imposed by the health maintenance organization with respect to enrollees who do not select the point-of-service benefit. Unless a group contract holder determines otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of any premium over the amount of the premium applicable to an enrollee who selects the coverage offered by the health maintenance organization without the point-of-service benefit and for any identifiable group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization; provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) thirty percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service benefit any condition or penalty designed to discourage the enrollee's selection or use of the point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

H. Except as expressly otherwise permitted in this section or as otherwise required under applicable law, the scope of the health care items and services which are covered under the point-of-service benefit required under this section shall at least include the same health care items and services which would be covered if provided under the health maintenance organization's health care plan, including without limitation any items or services covered under a rider or endorsement to the applicable health care plan. Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing materials utilized with respect to such group health benefit plans that the scope of the benefits provided under the point-of-service option are at least as great as those provided through the HMO's health care plan for that group. Filings of point-of-service benefits submitted to the Commission shall be accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the point-of-service benefits includes at a minimum the same health care items and services as are provided under the HMO's group health care plan for that group.

I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the health maintenance organization's group health benefit plan which does not contain the point-of-service benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is offered in a manner which separates or otherwise differentiates it from the group health benefit plan which does not contain the point-of-service benefit.

J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit under this section with respect to any group health benefit plan offered to a group contract holder if the health maintenance organization determines in good faith that the group contract holder will be concurrently offering another group health benefit plan or a self-insured or self-funded health benefit plan which allows the enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization's panel.

K. This section shall apply only to group health benefit plans issued in the Commonwealth in the commercial group market by carriers regulated by this title and shall not apply to (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 2 (§ 2.1-11.1 et seq.) of Title 2.1 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C.

L. This section shall apply to group health benefit plans issued or renewed by carriers in this Commonwealth on or after July 1, 1998.

M. Nothing in this section shall operate to limit any rights or obligations arising under §§ 38.2-3407, 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312 or § 38.2-4312.1.

N. If any provision of this section or its application to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity shall not affect the other provisions or any other application of this section which shall be given effect without the invalid provision or application, and for this purpose the provisions of this section are declared severable.

§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, 38.2-210 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, 38.2-1317 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, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, *38.2-3407.12*, 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, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 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, Chapter 9 (§38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, §§38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, *38.2-3407.12*, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§38.2-5300 et seq.) and Chapter 54 (§38.2-5400 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in §38.2-3431, a health maintenance organization providing health care plans pursuant to §38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

SENATE JOINT RESOLUTION NO. 97

Directing the Joint Commission on Health Care to continue its Long-Term Care Subcommittee and to continue its study of long-term care financing, licensure and other issues.

Agreed to by the Senate, March 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the population of the Commonwealth is rapidly aging; and

WHEREAS, Virginians 85 years of age and older are the fastest-growing segment of the state's population; and

WHEREAS, the demand for long-term care services is expected to increase rapidly; and

WHEREAS, the Medicaid program finances approximately 70 percent of the nursing home care provided in the Commonwealth; and

WHEREAS, long-term care expenditures by state government exceeded $500 million in fiscal year 1996; and

WHEREAS, the Joint Commission on Health Care's Long-Term Care Subcommittee has begun a study of long-term care and aging issues; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to continue its Long-Term Care Subcommittee.

In its deliberations, the subcommittee shall focus on (i) long-term care licensure and improvements in existing agencies; (ii) the feasibility of and necessity for a separate Department of Health Care Quality; (iii) the advantages and disadvantages of "deemed status" where accreditation is accepted in lieu of state licensure or federal certification; (iv) long-term care financing strategies, including long-term care insurance, blending Medicaid and Medicare for dually-eligible individuals, and creative use of Medicaid waivers; (v) strategies for increasing the number of graduates of Virginia medical schools who specialize in geriatric medicine; and (vi) other issues as may seem appropriate.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care and its staff, upon request.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

An estimated $65,000 is allocated for the cost of staff support for the completion of the study, to be funded by a separate appropriation from the General Assembly.

SENATE JOINT RESOLUTION NO. 99

Directing the Joint Commission on Health Care to study the need for an ombudsman program and an external appeals mechanism for insurance issues.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the Virginia Department of Health (VDH) conducted a 1997 study, pursuant to House Bill No. 2785, of the Role of the Commonwealth in Monitoring and Improving the Quality of Care in Managed Care Plans; and

WHEREAS, the VDH study made a number of recommendations for improving oversight of managed care plans; and

WHEREAS, the VDH study did not recommend pursuing either an ombudsman program or an external appeals mechanism; and

WHEREAS, the long-term care ombudsman program has been a successful model for mediating disputes; and

WHEREAS, certain other states have implemented an external appeals mechanism; and

WHEREAS, a consensus does not yet exist regarding the appropriateness of an external appeals mechanism or an ombudsman program for insurance issues; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study (i) the costs and benefits of an ombudsman program for health insurance issues and (ii) the costs and benefits of requiring an external appeals mechanism for managed care health insurance plans.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 104

Directing the Joint Commission on Health Care to study the tax incentives for the purchase of long-term care insurance.

Agreed to by the Senate, February 17, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the number of Virginians aged 85 and older is expected to nearly double between 1990 and 2010; and

WHEREAS, approximately 70 percent of nursing home services in Virginia are reimbursed through Medicaid funding; and

WHEREAS, in 1995, long-term care insurance policies in Virginia paid approximately $44 million in claims compared with approximately $470 million in Virginia Medicaid expenditures for long-term care services in 1995; and

WHEREAS, long-term care insurance is a policy that pays for the cost of receiving future long-term care; and

WHEREAS, long-term care insurance offers a means of promoting individual responsibility in meeting long-term care costs; and

WHEREAS, long-term care insurance offers a means of protecting an individual's assets from being depleted by long-term care costs and of enhancing consumer choice in selecting long-term care options; and

WHEREAS, the federal government, through the Health Insurance Portability and Accountability Act of 1996, created a provision whereby individuals may be able to deduct all or part of the premiums of a "qualified" long-term care policy if an individual's medical expenses exceed 7.5 percent of the individual's adjusted gross income; and

WHEREAS, according to the National Association of Insurance commissioners, 42,792 lives were covered by long-term care insurance policies in Virginia in 1995; and

WHEREAS, the challenge is how to encourage younger and/or healthier persons to purchase long-term care insurance for themselves or their family members; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study the tax incentives for the purchase of long-term care insurance. The study shall include (i) any appropriate tax incentives for an individual or the individual's family who would purchase a long-term care insurance policy on behalf of the individual; (ii) any additional alternative incentive plans, including Medicaid spend-down credits; and (iii) recommendations for a benefit package which provides insurance benefits to adequately and appropriately protect the interests of the insured and the Commonwealth.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 105

Requesting the Virginia Retirement System to report to the Joint Commission on Health Care regarding the feasibility of offering long-term care insurance to state and local employees.

Agreed to by the Senate, March 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the population of the Commonwealth is rapidly aging; and

WHEREAS, Virginians over the age of 85 are the fastest-growing segment of the State's population; and

WHEREAS, the demand for long-term services is expected to increase rapidly; and

WHEREAS, the Medicaid program finances approximately 70 percent of the nursing home care provided in the Commonwealth; and

WHEREAS, long-term care insurance offers a means of encouraging family and individual responsibility for long-term care insurance programs; and

WHEREAS, the Virginia Retirement System currently administers a group life and optional group life program for state and local employees; and

WHEREAS, the Joint Commission on Health Care's Long-Term Care Subcommittee is currently studying long-term care financing issues, including long-term care insurance; now, therefore be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the Virginia Retirement System (VRS) be requested to report to the Joint Commission on Health Care regarding the feasibility of offering long-term care insurance for state and local employees and VRS retirees. VRS should consider the feasibility of offering long-term care insurance as a stand-alone product or as a rider to the existing group life or optional group life programs.

The VRS shall report its findings to the Joint Commission on Health Care by October 1, 1998.

The Joint Commission on Health Care shall consider the VRS's report, the ongoing deliberations of the Commission on the Management of the Commonwealth's Workforce, and other information as may seem appropriate in formulating recommendations to the 1999 General Assembly.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care and its staff, upon request.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1999 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 112

Requesting the State Department of Health, in cooperation with appropriate public and private entities, to study opportunities for agencies of the Commonwealth to support Virginia's Free Clinics, the Virginia Association of Free Clinics, and the Community and Migrant Health Centers.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, low income, uninsured Virginias are among the most vulnerable populations in terms of access to affordable, quality health care services; and

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 858,000 persons had no health insurance of any kind, and that 66 percent of those persons lived in households with annual incomes less than 200 percent of the Federal Poverty Level; and

WHEREAS, Free Clinics are private, not-for-profit community-based organizations which provide access to primary health care services for low income, uninsured, and medically underserved populations; and

WHEREAS, Virginia's 30 Free Clinics, the most of any state in the country, serve patients in 83 localities across the Commonwealth; and

WHEREAS, Free Clinics provided health care services to more than 40,000 low income, uninsured, and medically underserved Virginians in 1996 through the volunteer efforts of over 1,900 physicians, 100 nurse practitioners and physician assistants, 250 dentists, 250 pharmacists, and hundreds of other health care professionals; and

WHEREAS, the Virginia Association of Free Clinics, founded in 1993, serves as an advocate for the member clinics and the populations they serve; and

WHEREAS, Virginia's Free Clinics have been supported primarily by cash and in-kind donations from the private sector, Virginia Health Care Foundation grants, and limited contributions from local governments; and

WHEREAS, Community and Migrant Health Centers are private, nonprofit, community-based organizations providing access to low income, uninsured and medically underserved populations; and

WHEREAS, in 1997, the Community and Migrant Health Centers provided primary health care services to more than 150,000 Virginians through over 400,000 patient visits; and

WHEREAS, direct or indirect financial support from the Commonwealth could increase the capacity of the Free Clinics and Community Migrant Health Centers to serve Virginia's indigent and uninsured populations; and

WHEREAS, the efficiency and effectiveness of the Free Clinics and Community and Migrant Health Centers could be improved substantially through enhanced coordination with state government agencies regarding the delivery of health care services, acquisition of surplus medical and dental equipment, participation in certain state purchasing contracts, and other collaborative activities; now, therefore, be it

RESOLVED, by the Senate, the House of Delegates concurring, That the State Department of Health, in cooperation with the Joint Commission on Health Care, the Department of Health Professions, the Board of Pharmacy, the Department of Medical Assistance Services, the Department of Social Services, the State Area Health Education Centers Program, the Commonwealth's academic health centers, other appropriate public and private entities, and health care consumer advocates, be requested to study opportunities for agencies of the Commonwealth to support the Free Clinics, the Virginia Association of Free Clinics, and the Community and Migrant Health Centers. The study shall include, but not be limited to: (i) an assessment of how the Free Clinics and Community and Migrant Health Centers might benefit from direct or indirect state funding, the mechanism by which such funds might be allocated, and the purpose for which such funds might be sought; (ii) an analysis of how the Free Clinics and Community and Migrant Health Centers might purchase equipment, supplies and services through state purchasing contracts and state service providers; (iii) an analysis of how the Board of Pharmacy and the Virginia Association of Free Clinics can work collaboratively to enhance the ability of Free Clinics to provide medications to the uninsured; (iv) an analysis of how the Department of Health and other state agencies might donate equipment such as dental trailers and computers to the Free Clinics and Community and Migrant Health Centers; (v) an assessment of how the Free Clinics and Community and Migrant Health Centers might be utilized for clinical practice sites for medical and dental educational programs and other health professional training programs; (vi) an analysis of a mechanism through which the

Free Clinics and Community and Migrant Health Centers might procure medical records from state agencies at no charge; (vii) an analysis of how the Free Clinics, Community and Migrant Health Centers, and local Departments of Social Services can collaborate on providing access to health through Medicaid enrollment; and (viii) an examination of how tax credits and other incentives for health care professionals and businesses may be developed, expanded, or amended to support the Free Clinics and Community and Migrant Health Centers.

The Department of Health shall report its findings and recommendations to the Joint Commission on Health Care by October 1, 1998, and shall submit its final report to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 119

Requesting the Department of Social Services and the Joint Commission on Health Care to report on the implementation of recommendations made by the Joint Legislative Audit and Review Commission and other issues related to licensure of adult care residences and adult day care centers.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the Department of Social Services (DSS) is responsible for licensure of adult care residences and adult day care centers; and

WHEREAS, the licensure process is an important part of ensuring quality care in long-term care facilities; and

WHEREAS, the 1996 General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to study services for mentally disabled residents of adult care residences; and

WHEREAS, the JLARC study identified significant deficiencies in the DSS licensure program for adult care residences; and

WHEREAS, continuous quality improvement should be an important part of ensuring quality in long-term care; and

WHEREAS, adequate staffing and training of the adult care licensure program are important parts of the program's success; and

WHEREAS, the Joint Commission on Health Care's Long-Term Care Subcommittee is currently studying long-term care licensure; and

WHEREAS, the Joint Commission on Health Care's 1997 study of long-term care identified concerns regarding the DSS adult care licensure program; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Social Services be requested to report to the Chairmen of the House Committee on Health, Welfare and Institutions; the Senate Committee on Rehabilitation and Social Services; and the Joint Commission on Health Care by October 1, 1998, regarding the status of its implementation of recommendations made by JLARC, the extent to which the licensure process is being used to encourage continuous quality improvement; and staffing and training needs with the adult care component of the DSS licensure program; and, be it

RESOLVED FURTHER, That the Joint Commission on Health Care shall evaluate (i) the report of the Department of Social Services, (ii) the status of the recommendations made in JLARC's 1990 and 1997 reports on adult care residences, (iii) the appropriateness of current regulations for protecting the health, safety, and welfare of residents of adult care residences as well as the interests of surrounding neighborhoods, and (iv) other issues as may seem appropriate.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care and its staff, upon request.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 120

Requesting the Department of Medical Assistance Services to study issues regarding current Medicaid nursing home reimbursement.

Agreed to by the Senate, February 16, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, nursing home occupancy rates are declining across the country; and

WHEREAS, in Virginia, current Medicaid nursing home reimbursement assumes a 95 percent occupancy rate for maximum Medicaid reimbursement; and

WHEREAS, certain Virginia planning districts are not projected to reach 95 percent occupancy rates before the year 2000; and

WHEREAS, alternative long-term care services will potentially further decrease occupancy rates in nursing facilities; and

WHEREAS, there is concern that continuing care retirement communities are negatively impacting the occupancy rates of freestanding nursing homes, particularly in the private-pay segment; and

WHEREAS, the Joint Commission on Health Care study on nursing homes and continuing care retirement communities, pursuant to Senate Bill No. 1139 (1997), suggests that additional information is necessary to determine the appropriateness of the current Medicaid reimbursement policy; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Medical Assistance Services be requested to study issues regarding Medicaid nursing home reimbursement. In conducting its study, the Department shall study (i) what factors are contributing to changes in Medicaid reimbursement levels in freestanding nursing homes; (ii) the current nursing home reimbursement policy, including the appropriateness of the 95 percent occupancy standard; and (iii) the appropriateness of remodeling the formulas for predicting bed-need levels and occupancy rates to take into account only those continuing care retirement community nursing beds that are open to the community and do not require a bona fide contract with the continuing care retirement community and those nursing home beds in freestanding nursing facilities that are not "frozen" for admissions as the result of licensing sanctions.

The Department of Medical Assistance Services shall complete its work in time to submit its findings and recommendations to the Joint Commission on Health Care by October 1, 1998, and to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 124

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, and the Department of Personnel and Training, to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics.

Agreed to by the Senate, March 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, pursuant to Senate Joint Resolution No. 298 of the 1997 Session of the General Assembly, the Joint Commission on Health Care recently completed a comprehensive study of how to reduce the number of uninsured persons in Virginia; and

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, the percentage of Virginia's uninsured adults who are employed full time has increased from 41 percent in 1993 to 57 percent in 1996; and

WHEREAS, when purchasing health insurance coverage, small employers generally pay higher administrative costs, have less negotiating power with insurance carriers, often are considered a greater insurance risk, and pay higher premiums than large employers; and

WHEREAS, because of the difficulties small employers face in purchasing health insurance coverage, the percentage of employees who are uninsured is much greater among small employers than large employers; and

WHEREAS, there are 42 community health centers and 30 free clinics across the Commonwealth which provide valuable health care services to many of Virginia's uninsured and indigent persons; and

WHEREAS, through the Joint Commission on Health Care's study of the indigent and uninsured, it was determined that the community health centers and free clinics have encountered many of the same difficulties as other small employers in purchasing health insurance coverage for their employees; and

WHEREAS, health insurance purchasing pools enable small employers to "pool" their purchasing power, a practice which provides them with many of the same purchasing advantages of large groups; and

WHEREAS, at least 20 states have enacted laws to establish state-sponsored health insurance purchasing pools or encourage the development of private pools; and

WHEREAS, Virginia's business community has expressed significant interest in pursuing the possible development of a health insurance purchasing pool for small employers; and

WHEREAS, detailed study and analysis are needed to determine more definitively the type of pooled purchasing arrangement that would be of the greatest interest to small employers and the key elements that would need to be included for such an arrangement to be successful in Virginia; and

WHEREAS, pursuant to §2.1-20.1:02 of the Code of Virginia, the Department of Personnel and Training administers THE LOCAL CHOICE program as an optional health insurance program for local governments, school divisions, constitutional officers, and other governmental entities which can elect to purchase health insurance coverage for their employees through the program; and

WHEREAS, THE LOCAL CHOICE program functions in many respects like a pooled purchasing arrangement and provides many purchasing advantages for small governmental entities; and

WHEREAS, THE LOCAL CHOICE program has been successful since its inception in 1990, is financially strong, and currently provides health insurance to approximately 190 groups and 22,000 eligible employees; and

WHEREAS, additional study of THE LOCAL CHOICE program is needed to determine the advantages and disadvantages of expanding the program to include small employers, community health centers, and free clinics, without causing any adverse impact on the groups currently participating in the program; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, and the Department of Personnel and Training be directed to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics. The Joint Commission also shall consult with health care consumer advocates in conducting the study. The Joint Commission's study shall include, but not be limited to, (i) evaluating the pooled purchasing arrangements operating in California, Florida, and other states; (ii) assessing the level of interest among Virginia's small employers in participating in a health insurance purchasing pool; (iii) analyzing the key elements of such a purchasing pool to maximize the number of participating employers; and (iv) identifying health insurance market reforms or other actions necessary to ensure the success of a purchasing pool; and, be it

RESOLVED FURTHER, That, as part of its study, the Joint Commission shall study THE LOCAL CHOICE program and its potential as a model for pooled purchasing of health insurance for small employers, community health centers and free clinics. In conducting this portion of its study, the Joint Commission on Health Care shall also consult with the Department of Personnel and Training, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Manufacturers Association, the Virginia Chapter of the National Federation of Independent Businesses, the Virginia Primary Care Association and the Virginia Association of Free Clinics. Actuarial work, estimated to cost $50,000, will be required for the Joint Commission on Health Care to complete the study.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 125

Directing the Joint Commission on Health Care to continue its study of ways to improve access to health care for Virginia's indigent and uninsured population.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, pursuant to Senate Joint Resolution No. 298 (1997), the Joint Commission on Health Care recently completed a comprehensive study of how to reduce the number of uninsured persons in Virginia; and

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons are uninsured; and

WHEREAS, the 1996 survey found that the cost of health insurance coverage continues to be the most frequently-cited reason for being uninsured; and

WHEREAS, while the total number of uninsured Virginians has remained relatively stable over the last several years, the recent Joint Commission on Health Care study found significant changes in the demographics of Virginia's uninsured population, and identified several emerging issues regarding the indigent and uninsured which will need to be monitored; and

WHEREAS, research by the Joint Commission on Health Care and other national studies have found that there are a number of significant adverse consequences of being uninsured, as evidenced by the fact that when compared to persons with insurance, uninsured persons visit hospitals and doctors' offices less frequently, are one-half as likely to regularly go to a dentist, are three times more likely not to get a prescription filled because it costs too much, and receive fewer primary and preventive health care services; and

WHEREAS, in recent years, the Commonwealth has implemented a number of initiatives to address the uninsured problem, such as insurance market reforms designed to make insurance coverage more available and affordable, programs such as the Indigent Health Care Trust Fund and the State and Local Hospitalization Program to help offset the cost of uncompensated hospital care, and initiatives, such as the Virginia Health Care Foundation, that provide financial support to primary care and other health care programs targeted to indigent and uninsured persons; and

WHEREAS, it is critical to monitor the impact of these and other initiatives to ensure that they are meeting their stated objectives, and to identify and implement any necessary modifications to enhance their effectiveness; and

WHEREAS, the Indigent Health Care Trust Fund was established to help offset the expenses incurred by Virginia's private acute care hospitals in providing care to the Commonwealth's indigent population; and

WHEREAS, the Indigent Health Care Trust Fund Technical Advisory Panel has been working for several years to establish a pilot program for subsidizing private health insurance for the working poor, but has not yet been successful in implementing the program; and

WHEREAS, more detailed analysis of the Indigent Health Care Trust Fund and the proposed pilot program is needed to determine their effectiveness; and

WHEREAS, one of the many issues examined by the Joint Commission in its study of the indigent and uninsured is the impact that not-for-profit to for-profit hospital conversions may be having on indigent and uninsured persons in the Commonwealth; and

WHEREAS, one of the major concerns regarding hospital conversions is the impact such conversions may be having on the provision of health care services that not-for-profit hospitals historically have provided to indigent and uninsured persons; and

WHEREAS, because most of the hospital conversions in Virginia have taken place within the last few years, there is little available information regarding the impact these actions are having on the provision of health care services to the Commonwealth's indigent and uninsured populations; and

WHEREAS, the State Children's Health Insurance Program (SCHIP) was included in the Balanced Budget Act of 1997 to provide funding to states to expand health insurance coverage for low-income uninsured children; and

WHEREAS, it will be necessary to monitor the implementation of this program in Virginia to ensure that it is meeting its stated objectives of expanding insurance coverage to uninsured children; and

WHEREAS, as part of the implementation of SCHIP, a comprehensive outreach program needs to be established and monitored to ensure that families with children eligible for SCHIP and families of the estimated 82,000 children eligible for, but not enrolled in, Medicaid are informed of these respective programs; and

WHEREAS, it is essential to continue to identify and assess new initiatives or programs that can further improve access to health care for the indigent and reduce the number of uninsured persons; and

WHEREAS, continuing research on the number and demographics of uninsured persons in Virginia is needed to maintain a current data base of information, track emerging trends, assess the impact of past initiatives to reduce the number of uninsured persons, and help formulate new actions or initiatives that are responsive to specific problem areas; and

WHEREAS, one of the founding purposes of the Joint Commission on Health Care was to ensure that the greatest number of Virginians receive quality, cost-effective health care services, including the indigent and uninsured populations; and

WHEREAS, to fulfill this purpose, continuing analysis and study of the various issues affecting Virginia's indigent and uninsured populations is needed; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with various governmental, public and private health care entities and consumer advocates, be continued to study the provision of health care for the indigent and uninsured, including the aged population and persons living in rural and inaccessible areas of the state, and to monitor various issues affecting these populations. The Joint Commission's continuing work shall include, but not be limited to: (i) evaluating the impact of recent initiatives to address the problems of the indigent and uninsured; (ii) assessing the progress in reducing the number of uninsured persons in Virginia; (iii) assessing the affordability of health insurance coverage, particularly for small employers, and the impact that state mandates and other legislative actions have on the cost of coverage; (iv) monitoring changes in federal and state health care policy that may affect the indigent and uninsured; (v) identifying additional actions to further improve access to care for the indigent and uninsured; (vi) monitoring the implementation of the State Children's Health Insurance Program (SCHIP) and the outreach programs established to inform families about the SCHIP and Medicaid programs; (vii) conducting a detailed analysis of the Indigent Health Care Trust Fund to determine the effectiveness of this program; (viii) monitoring the impact that the conversion of not-for-profit hospitals to for-profit status may be having on the indigent and uninsured; (ix) conducting necessary population surveys and other data analyses to update the number and demographics of the uninsured; and (x) recommending other necessary actions to ensure that the Commonwealth continues to improve access to care for the indigent and uninsured.

The Joint Commission on Health Care shall conduct its continuing study during the next three years, and shall include its findings and recommendations in its 1998, 1999, and 2000 annual reports to the Governor and General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 126

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to continue its study on the feasibility of establishing a high risk insurance pool in Virginia.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the Joint Commission on Health Care recently completed a study of high risk insurance pools and the feasibility of establishing such a pool in Virginia, pursuant to Senate Joint Resolution No. 337 of the 1997 Session of the General Assembly; and

WHEREAS, high risk pools have been established in 25 states as a means of providing health insurance coverage for small groups and individuals who, because of serious medical conditions, have been unable to purchase health insurance in the marketplace; and

WHEREAS, there are advantages and disadvantages to implementing a high risk pool; and

WHEREAS, "open enrollment" programs are used in 11 states, including Virginia and the District of Columbia, to provide coverage for uninsurable individuals; and

WHEREAS, in Virginia's open enrollment program, Trigon Blue Cross/Blue Shield and Blue Cross and Blue Shield of the National Capital Area function as open enrollment carriers and provide coverage to individuals regardless of health status; and

WHEREAS, Virginia's two open enrollment carriers reported a combined total of approximately 11,300 individuals being covered under the open enrollment program in 1995; and

WHEREAS, the actual number of uninsurable persons covered through the open enrollment program is unknown but is somewhat less than 11,300; and

WHEREAS, the Commonwealth imposes a reduced premium license tax on taxable premiums of open enrollment carriers derived from individual policies to help offset the carriers' underwriting losses incurred as a result of the open enrollment program; and

WHEREAS, the reduced license tax on open enrollment carriers amounted to approximately $5.2 million in taxable year 1995; and

WHEREAS, the Health Insurance Portability and Accountability Act of 1996 reduces the need for high risk pools or other "safety net" programs in the small group market; and

WHEREAS, a key policy issue regarding the feasibility of implementing a high risk pool in Virginia is whether such an arrangement would provide a better and more cost effective "safety net" for uninsurable person than the current open enrollment program; and

WHEREAS, a thorough analysis of the number and types of persons in Virginia with serious medical conditions is needed to determine how these individuals currently are obtaining coverage, and what premiums they are having to pay for the coverage; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, be directed to continue its study of the feasibility of establishing a high risk pool in Virginia. The Joint Commission's study shall include, but not be limited to, a more detailed analysis of (i) the problems encountered by high risk individuals in obtaining affordable health insurance coverage; (ii) whether the current open enrollment program, a high risk pool, or other mechanism would best serve the needs of persons with high risk medical needs in terms of costs and benefits; (iii) which type of approach provides the best mechanism for insuring high risk persons in terms of its impact on the health insurance market as a whole; (iv) which type of program provides the Commonwealth with the best approach to insuring high risk individuals; and (v) the practicality of administering both an open enrollment program and a high risk pool similar to the programs operating in Colorado. The Joint Commission shall consult with various consumer advocates in conducting the study.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative

SENATE JOINT RESOLUTION NO. 127

Requesting the Center for Pediatric Research to continue its research regarding pediatric care in Virginia.

Agreed to by the Senate, February 16, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the Commonwealth of Virginia desires quality health care services and optimal health care outcomes for its children; and

WHEREAS, the Center for Pediatric Research (CPR), a joint venture of Eastern Virginia Medical School and Children's Hospital of The King's Daughters, has published a report regarding children's health under a grant from the Virginia Department of Health; and

WHEREAS, the CPR study found in 1995 that 149,817 children, ages newborn to 19 years, were discharged from hospitals in the Commonwealth and of that number, 68,926 were non-newborns; and

WHEREAS, for the non-newborn discharges the most frequent discharge conditions were bronchiolitis/bronchitis, asthma, pneumonia, and gastroenteritis for the children 0 to 4 years old; asthma, unintentional injuries, pneumonia, and gastroenteritis for five- to nine-year-olds; depression, unintentional injuries, asthma, and behavior disorders for 10- to 14-year-olds; deliveries, depression, unintentional injuries, and manic depression for 15- to 19-year-olds; and

WHEREAS, discharge rates normalized for the population at risk for these conditions varied by geographic area; and

WHEREAS, with the information that currently exists, it cannot be determined if the geographic differences are due to access to health care, economic backgrounds, hospital type, or cultural or other factors; and

WHEREAS, further analysis is needed to determine the cause of these significant variations in the care delivered to children in the Commonwealth and to determine the optimal type of hospital care; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Center for Pediatric Research be requested to continue its research regarding pediatric care. Optimally, the work will determine (i) what factors influence differences in the pediatric discharge rates by geographic area, (ii) what impact these differences may have on the quality and outcomes of pediatric care, and (iii) the optimal way to publicly disseminate these findings on an ongoing basis.

The Center for Pediatric Research shall complete its work in time to present its findings and recommendations to the Joint Commission on Health Care by October 1, 1998, and shall submit its final report to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

An estimated $75,000 is allocated for the Center for Pediatric Research for the completion of this study. Such expenses shall be funded by a separate appropriation by the General Assembly.

HOUSE JOINT RESOLUTION NO. 156

Directing the Joint Commission on Health Care to continue its Long-Term Care Subcommittee and to continue its study of long-term care financing, licensure, and other issues.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, the population of the Commonwealth is rapidly aging; and

WHEREAS, Virginians 85 years of age and older are the fastest-growing segment of the state's population; and

WHEREAS, the demand for long-term care services is expected to increase rapidly; and

WHEREAS, the Medicaid program finances approximately 70 percent of the nursing home care provided in the Commonwealth; and

WHEREAS, long-term care expenditures by state government exceeded $500 million in fiscal year 1996; and

WHEREAS, the Joint Commission on Health Care's Long-Term Care Subcommittee has begun a study of long-term care and aging issues; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to continue its Long-Term Care Subcommittee and its study of long-term care financing, licensure and other issues.

In its deliberations, the subcommittee shall focus on (i) long-term care licensure and improvements in existing agencies; (ii) the feasibility of and necessity for a separate Department of Health Care Quality; (iii) the advantages and disadvantages of "deemed status" where accreditation is accepted in lieu of state licensure or federal certification; (iv) long-term care financing strategies, including long-term care insurance, blending Medicaid and Medicare for dually-eligible individuals, and creative use of Medicaid waivers; (v) strategies for increasing the number of graduates of Virginia medical schools who specialize in geriatric medicine; and (vi) other issues as may seem appropriate.

All agencies of the Commonwealth shall provide assistance to the Commission and its staff, upon request.

The Commission shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

An estimated $65,000 is allocated for the cost of staff support for the completion of the study to be funded by a separate appropriation from the General Assembly.

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HOUSE JOINT RESOLUTION NO. 175

Offered January 26, 1998

Requesting the Commissioner of the Virginia Department of Health to assume a lead role in encouraging, assisting, and supporting local health summits.

Patrons-- Morgan, Baker, Diamonstein and Hall; Senators: Bolling, Gartlan, Lambert, Martin, Schrock, Walker and Woods

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Referred to Committee on Health, Welfare and Institutions

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 were uninsured; and

WHEREAS, indigent and uninsured Virginians are among the most vulnerable populations in terms of access to affordable, quality health care services; and

WHEREAS, research by the Joint Commission on Health Care and other national studies have found that there are a number of significant adverse consequences of being uninsured, as evidenced by the fact that when compared to persons with insurance, uninsured persons (i) visit hospitals and doctors' offices less frequently, (ii) are one-half as likely to regularly go to a dentist, (iii) are three times more likely not to get a prescription filled because it costs too much, and (iv) receive fewer primary and preventive health care services; and

WHEREAS, while a number of initiatives have been implemented to improve access to care for the indigent and uninsured, there continues to be an urgent need for public and private entities to work collaboratively and monitor specific needs of the indigent and uninsured, identify programs and initiatives to address these needs, and evaluate the impact of new programs and initiatives; and

WHEREAS, many hospitals, in cooperation with local health officials, businesses, insurers, and consumer groups, are conducting needs assessments of their respective communities as part of the Virginia Hospital and Healthcare Association's Task Force on Community Health and Accountability; and

WHEREAS, the Department of Health, in cooperation with several state agencies and other public and private entities, sponsored the Virginia Health care Access Summit in 1997 to engage health care decision-makers from across the state in defining health care access problems, proposing solutions, and initiating action to address the problems; and

WHEREAS, the participants in the Virginia Health Care Access Summit identified a number of actions to address the problems of the indigent and uninsured, including (i) educating and building support among legislators for addressing the problems of the indigent and uninsured, (ii) building consensus for changes within the health care provider community, (iii) implementing outreach and educational campaigns to make indigent and uninsured persons aware of the various programs that provide health care services for the indigent and uninsured, and (iv) encouraging local and regional collaboration among various public and private entities in implementing effective health care programs; and

WHEREAS, the Virginia Health Care Access Summit participants suggested that local health care summits convene to serve as a catalyst for identifying local needs pertaining to the indigent and uninsured and for implementing programs to address these needs; and

WHEREAS, such local health care summits could bring together health care providers, policy makers, purchasers, insurers, and consumers to focus on local issues as a complement to the statewide efforts aimed at the needs of the indigent and uninsured; and

WHEREAS, the leadership among health care officials and organizations is diverse and varies from community to community; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Commissioner of the Virginia Department of Health be requested to assume a lead role in encouraging local governments, local public and private health care programs, local health care policy makers, provider groups, consumer groups, businesses, and insurers to collaboratively sponsor local health summits to serve as a catalyst for continued attention to the indigent and uninsured populations in each locality.

To provide assistance and support for these programs, the Commissioner shall develop a process for summarizing and

disseminating information on the key actions and deliberations of local summits to other localities and to state level health care organizations as a means of facilitating information-sharing across the Commonwealth on critical health care issues. The Commissioner shall work in cooperation with consumer advocates and other health care organizations, including the Virginia Health Care Foundation, the Virginia Hospital and Healthcare Association, the Virginia Association of Regional Health Planning Agencies, the Virginia Association of Free Clinics, and the Virginia Primary Care Association.

The Commissioner of the Virginia Department of Health shall report the status of local health summits and his activities to the Joint Commission on Health Care by October 1, 1998, and shall submit his final report to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 179

Requesting foundations formed in Virginia as a result of hospitals converting from not-for-profit to for-profit status to annually update the Joint Commission on Health Care on their charitable activities.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, pursuant to Senate Joint Resolution No. 298 (1997), the Joint Commission on Health Care recently completed a comprehensive study of how to reduce the number of uninsured persons in Virginia; and

WHEREAS, one of the many issues examined by the joint commission in its study of the indigent and uninsured is the impact that not-for-profit to for-profit hospital conversions may be having on indigent and uninsured persons in the Commonwealth; and

WHEREAS, in recent years the number of hospitals converting from not-for-profit to for-profit status has increased substantially; and

WHEREAS, one of the major concerns regarding hospital conversions is the impact such conversions may be having on the provision of health care services that not-for-profit hospitals historically have provided to indigent and uninsured persons; and

WHEREAS, one of the trends that has accompanied the increase in hospital conversions has been the establishment of foundations; and

WHEREAS, foundations often are formed as a way to ensure that the converting organization's assets (i) continue to be used for charitable purposes, (ii) pay back the public for years of tax-exempt status, and (iii) are not used as additional profits for the for-profit company; and

WHEREAS, one means for these foundations to continue the original charitable mission of the not-for-profit hospitals is to provide funding for various health care programs and services targeted to indigent and uninsured persons; and

WHEREAS, five hospitals in Virginia have converted from not-for-profit to for-profit status in recent years and have established conversion foundations; and

WHEREAS, because most of the conversion foundations established in Virginia have been formed within the last few years, there is little available information regarding the impact these entities are having on indigent and uninsured persons in their communities; and

WHEREAS, although the conversion foundations in Virginia have funded many worthwhile and important health care projects, there has been minimal information sharing and coordination between the Commonwealth and the conversion foundations regarding the provision and financing of services for the indigent and uninsured; and

WHEREAS, the conversion foundations can play a key role in the Commonwealth's overall strategy for improving access to care for indigent and uninsured persons; and

WHEREAS, the impact and effectiveness of limited financial resources can be optimized through greater information sharing and coordination of efforts between the Commonwealth and the conversion foundations; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the foundations formed in Virginia as a result of the conversion of not-for-profit hospitals to for-profit status be requested to annually update the Joint Commission on Health Care on the charitable activities of their respective organizations, including information on (i) the total dollar amount expended on charitable activities, (ii) the health care programs and other projects funded during the year, (iii) the type of indigent and uninsured populations served, and (iv) the ways in which the activities of the foundations and the Commonwealth could be coordinated to have a greater impact on providing care to the indigent and reducing the number of uninsured persons; and, be it

RESOLVED FURTHER, That the Joint Commission be directed to involve the foundations in its ongoing planning and assessment of initiatives and other actions to address the problems of the Commonwealth's indigent and uninsured populations.

HOUSE JOINT RESOLUTION NO. 180

Requesting the Center for Pediatric Research to continue its research regarding pediatric care in Virginia.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, the Commonwealth of Virginia desires quality health care services and optimal health care outcomes for its children; and

WHEREAS, the Center for Pediatric Research (CPR), a joint venture of Eastern Virginia Medical School and Children's Hospital of The King's Daughters, has published a report regarding children's health under a grant from the Department of Health; and

WHEREAS, the CPR study found in 1995 that 149,817 children, ages newborn to 19 years, were discharged from hospitals in the Commonwealth, and of that number, 68,926 were non-newborns; and

WHEREAS, for the non-newborn discharges the most frequent discharge conditions were bronchiolitis/bronchitis, asthma, pneumonia, and gastroenteritis for the children 0 to 4 years old; asthma, unintentional injuries, pneumonia, and gastroenteritis for 5 to 9 year olds; depression, unintentional injuries, asthma, and behavior disorders for 10 to 14 year olds; deliveries, depression, unintentional injuries, and manic depression for 15 to 19 year olds; and

WHEREAS, discharge rates normalized for the population at risk for these conditions varied by geographic area; and

WHEREAS, with the information that currently exists, it cannot be determined if the geographic differences are due to access to health care, economic backgrounds, hospital type, or cultural or other factors; and

WHEREAS, further analysis is needed to determine the cause of these significant variations in the care delivered to children in the Commonwealth and to determine the optimal type of hospital care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Center for Pediatric Research be requested to continue its research regarding pediatric care. Optimally, the work will determine (i) what factors influence differences in the pediatric discharge rates by geographic area, (ii) what impact these differences may have on the quality and outcomes of pediatric care, and (iii) the optimal way to publicly disseminate these findings on an ongoing basis.

The Center for Pediatric Research shall complete its work in time to present its findings and recommendations to the Joint Commission on Health Care by October 1, 1998, and shall submit its final report to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

An estimated $75,000 is allocated for the Center for Pediatric Research for the completion of this study. Such expenses shall be funded by a separate appropriation by the General Assembly.

HOUSE JOINT RESOLUTION NO. 202

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, and the Department of Personnel and Training, to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics.

Agreed to by the House of Delegates, March 12, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, pursuant to Senate Joint Resolution No. 298 (1997), the Joint Commission on Health Care recently completed a comprehensive study of how to reduce the number of uninsured persons in Virginia; and

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, the percentage of Virginia's uninsured adults who are employed full-time has increased from 41 percent in 1993 to 57 percent in 1996; and

WHEREAS, when purchasing health insurance coverage, small employers generally pay higher administrative costs, have less negotiating power with insurance carriers, often are considered a greater insurance risk, and pay higher premiums than larger employers; and

WHEREAS, because of the difficulties small employers face in purchasing health insurance coverage, the percentage of employees who are uninsured is much greater among small employers than larger employers; and

WHEREAS, there are 42 community health centers and 30 free clinics across the Commonwealth which provide valuable health care services to many of Virginia's uninsured and indigent persons; and

WHEREAS, through the Joint Commission on Health Care's study of the indigent and uninsured, it was determined that the community health centers and free clinics have encountered many of the same difficulties as other small employers in purchasing health insurance coverage for their employees; and

WHEREAS, health insurance purchasing pools enable small employers to "pool" their purchasing power which provides them with many of the same purchasing advantages of larger groups; and

WHEREAS, at least 20 states have enacted laws to establish state-sponsored health insurance purchasing pools or encourage the development of private pools; and

WHEREAS, Virginia's business community has expressed significant interest in pursuing the possible development of a health insurance purchasing pool for small employers; and

WHEREAS, detailed study and analysis is needed to determine more definitively the type of pooled purchasing arrangement that would be of the greatest interest to small employers and the key elements that would need to be included for such an arrangement to be successful in Virginia; and

WHEREAS, pursuant to §2.1-20.1:02 of the Code of Virginia, the Department of Personnel and Training administers THE LOCAL CHOICE program as an optional health insurance program for local governments, school divisions, constitutional officers, and other governmental entities which can elect to purchase health insurance coverage for their employees through the program; and

WHEREAS, THE LOCAL CHOICE program functions in many respects like a pooled purchasing arrangement and provides many purchasing advantages for small governmental entities; and

WHEREAS, THE LOCAL CHOICE program has been successful since its inception in 1990, is financially strong, and currently provides health insurance to approximately 190 groups and 22,000 eligible employees; and

WHEREAS, additional study of THE LOCAL CHOICE program is needed to determine the advantages and disadvantages of expanding the program to include small employers, community health centers, and free clinics, without causing any adverse impact on the groups currently participating in the program; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation

with the Bureau of Insurance, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, and the Department of Personnel and Training be directed to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics. The Joint Commission shall consult with health care consumer advocates in conducting the study. The Joint Commission's study shall include, but not be limited to, (i) evaluating the pooled purchasing arrangements operating in California, Florida, and other states; (ii) assessing the level of interest among Virginia's small employers in participating in a health insurance purchasing pool; (iii) analyzing the key elements of such a purchasing pool to maximize the number of participating employers; and (iv) identifying health insurance market reforms or other actions necessary to ensure the success of a purchasing pool; and, be it

RESOLVED FURTHER, That, as part of its study, the Joint Commission shall study THE LOCAL CHOICE program and its potential as a model for pooled purchasing of health insurance for small employers, community health centers and free clinics. In conducting this portion of its study, the Joint Commission shall consult with the Department of Personnel and Training, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Manufacturers Association, the Virginia Chapter of the National Federation of Independent Business, the Virginia Primary Care Association and the Virginia Association of Free Clinics. Actuarial work, estimated to cost $50,000, will be required for the Joint Commission on Health Care to complete the study.

The Joint Commission shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 209

Directing the Joint Legislative Audit and Review Commission to study the mission and effectiveness of the organization, operation, and performance of the Department for the Aging.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, the Department for the Aging is the Commonwealth's single state agency responsible for administration of the Older Americans Act; and

WHEREAS, the Joint Commission on Health Care has identified concerns regarding the effectiveness of the Department in assisting state policymakers in dealing with the increasing numbers of elderly Virginians; and

WHEREAS, a 1996 report by the Secretary of Health and Human Resources recommended strengthening the Department's education and research functions; and

WHEREAS, Virginians 85 years of age and older are the fastest-growing segment of the state population; and

WHEREAS, the Department's maximum employment level has been reduced from 32 to 22 positions; and

WHEREAS, the Department has several positions that have remained open for a long period of time; and

WHEREAS, long-term care financing is becoming increasingly complex with regard to managed care and blending Medicaid and Medicare financing for the dually eligible; and

WHEREAS, the Department does not currently have staff expertise in long-term care financing; and

WHEREAS, a need exists for coordination among the multiple state agencies involved in aging issues as distinct from long-term care issues; and

WHEREAS, a need exists for consumer education regarding long-term care and aging issues; and

WHEREAS, the Department plays a potentially important role in conducting research, policy analysis, and long-range planning on aging issues and on the challenges and opportunities presented by the growing number of older Virginians; and

WHEREAS, a strong Department is important to the Commonwealth's ability to prepare all state agencies and programs to best meet the needs of the growing number of older Virginians and their families; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission (JLARC) be directed to study the mission and effectiveness of the organization, operation, and performance of the Department for the Aging. The study shall examine (i) the mission of the Department and the extent to which such mission should extend beyond administration of the Older Americans Act; (ii) the effectiveness of the organization, operation, and performance of the Department in meeting its current mandate; (iii) the staffing of the Department with regard to its current mission; and (iv) any other activities as it may deem appropriate.

The Department shall cooperate fully as requested and make available all records, staff, and information necessary for the completion of work by JLARC and its staff. All agencies of the Commonwealth shall provide assistance to JLARC, upon request.

JLARC shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 210

Directing the Joint Commission on Health Care, in cooperation with the Departments of Health and Medical Assistance Services, to conduct a study of quality of care and reimbursement issues related to telemedicine.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, telemedicine is an emerging technology for the delivery of certain health care services; and

WHEREAS, the Department of Corrections is currently using telemedicine to deliver certain specialty services to inmates; and

WHEREAS, the Joint Commission on Health Care examined telemedicine issues in a 1995 study, published in 1996 as House Document 6; and

WHEREAS, a 1997 executive branch study was unable to reach consensus regarding telemedicine reimbursement for state programs; and

WHEREAS, health care payors have expressed concern that telemedicine has not yet been proven to deliver quality care and that routine reimbursement for telemedicine services may increase health care costs; and

WHEREAS, telemedicine potentially could improve access to health care in rural areas; and

WHEREAS, Virginia's academic medical centers have been active in investigating applications for telemedicine; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with the Departments of Health and Medical Assistance Services, be directed to conduct a study of quality of care and reimbursement issues related to telemedicine. The study shall include, but not be limited to, an examination of (i) the experience of other states with regard to reimbursement for telemedicine services and options for the Commonwealth in developing such reimbursement policy; (ii) what services can be cost-effectively and efficiently provided through telemedicine for which Medicaid reimbursement is appropriate; and (iii) the appropriate role for the Department of Health in identifying medically underserved areas of the Commonwealth in which telemedicine services could expand access to health care.

All agencies of the Commonwealth shall provide assistance to the Joint Commission and its staff for this study, upon request.

The Joint Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 224

Requesting the Department of Health to report to the Joint Commission on Health Care on its implementation of recommendations made by the Department of Medical Assistance Services and the University of Virginia in a 1997 study of the nursing home certification survey process and other issues related to the Department of Health's role in federal certification of nursing homes for participation in Medicaid and Medicare.

Agreed to by the House of Delegates, February 12, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, the Department of Health is responsible for licensure of nursing homes and for certifying nursing homes for participation in Medicaid and Medicare; and

WHEREAS, the nursing home certification survey process is an important part of ensuring quality care in nursing homes; and

WHEREAS, the nursing home certification survey process offers the opportunity for an educational partnership between state regulators and providers; and

WHEREAS, the 1997 Appropriation Act directed the Department of Medical Assistance Services (DMAS) to study the nursing home certification survey process; and

WHEREAS, this study conducted by DMAS and the University of Virginia identified the need for improved consistency, training, and communication in the federal nursing home certification survey process; and

WHEREAS, continuous quality improvement should be an important part of ensuring quality in long-term care in general and nursing home care in particular; and

WHEREAS, adequate staffing and training of the long-term care certification program are important parts of the program's success; and

WHEREAS, the Joint Commission on Health Care's Long-Term Care Subcommittee is currently studying licensure and certification of long-term care facilities; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health be requested to report to the Joint Commission on Health Care on its implementation of recommendations made by the Department of Medical Assistance Services and the University of Virginia in a 1997 study of the nursing home certification survey process and other issues related to the Department of Health's role in federal certification of nursing homes for participation in Medicaid and Medicare. The Department shall submit its report to the Commission and to the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by October 1, 1998. Other issues which should be included in this report are the extent to which the nursing home certification survey process is being used to encourage continuous quality improvement and the identification of staffing and training needs within the Department of Health's Division of Long-Term Care Services; and, be it

RESOLVED FURTHER, That the Joint Commission shall consider the Department of Health's report from the 1997 study by the Department of Medical Assistance Services and the University of Virginia and other information as it may deem appropriate in formulating recommendations to the 1999 Session of the General Assembly regarding the nursing home certification survey process.

All agencies of the Commonwealth shall provide assistance to the Joint Commission and its staff, upon request.

The Joint Commission shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B:

1998 Workplan

Proposed 1998 Meeting Schedule and Workplan

(Shaded Areas Represent JCHC Issue Briefs)

May 12, 9:30 AM

* Status of 1998 Legislation
* 1998 Workplan
* A Pocket Guide to Health Care in Virginia

June 15, 10 A.M.

* Election of Chair and Vice Chair
* 1997 Annual Report
* Reimbursement and Quality of Care Issues Regarding Telemedicine *(HJR 210, Delegate Baker)*
* Study on Health Workforce Planning and Funding Mechanism *(Budget Item 12#3c)*
* Update on the Implementation of the State Children's Health Insurance Program (SCHIP)

July 28, 10 A.M.

* Long-Term Care Study Phase I: Licensure Issues in Long-Term Care *(SJR 97, Senator Woods; HJR 156, Delegate Hall; SJR 119, Senator Gartlan)*
* Status Report on Department of Health's Study on Quality of Care Oversight *(1998; SB 712, Senator Martin)*
* Ombudsman Program/ External Appeals Mechanism *(SJR 99, Senator Lambert)*
* Status Report on the Implementation of the State Children's Health Insurance Program (SCHIP)

September 23, 10 A.M.

* Study of Pooled Purchasing Arrangements for Small Employers, Community Health Centers and Free Clinics *(SJR 124, Senator Walker; HJR 202, Delegate Melvin)*
* Long-Term Care Study Phase II: Financing of Long-Term Care and Other Long-Term Care Issues *(SJR 97, Senator Woods; HJR 156, Delegate Hall; SJR 104, Senator Martin; SJR 160, Senator Marye)*
* Study of the Health Status and Conditions of African-Americans in the Commonwealth *(1997, SJR 355, Senator Maxwell)*
* Study of Health Care Coverage for Anorexia Nervosa and Bulimia *(HJR 268, Delegate Devolites)*
* Study of Participation of Academic Health Centers in Managed Care Provider Networks *(SJR 108, Senator Bolling)*
* Status Report on "Turning Point" Initiative

October 20, 10 A.M.

* Update on Other Long-Term Care Studies *(SJR 105, Senator Martin; SJR 120, Senator Gartlan; HJR 209, Delegate Baker; HJR 224, Delegate Hall; Item 335#10C)*
* Study on the Feasibility of Establishing a High Risk Insurance Pool in Virginia *(SJR 126, Senator Walker)*
* Status Report on Virginia Health Information's Strategic Plan for Health Care Cost and Quality Data Initiatives *(1996, HB 1307, Delegate DeBoer)*
* Update on Indigent/Uninsured Issues *(SJR 125, Senator Walker)*:
    * VDH's Study of Ways to Support Free Clinics and Community/Migrant Health Centers *(SJR 112, Senator Schrock)*
    * Commissioner of Health's Report on Supporting Local Health Summits *(HJR 175, Delegate Morgan)*
    * Conversion Foundations' Report on Charitable Activities *(HJR 179, Delegate Diamonstein)*
    * Results of Carilion Health System's Study of Access to Prescription Drugs by Indigent Persons
* Summary of Other Reports:
    - Center for Pediatric Research Study on Pediatric Care *(SJR 127, Senator Walker; HJR 180, Delegate Diamonstein)*
* Status Report on State Children's Health Insurance Program

November 17, 10 A.M.

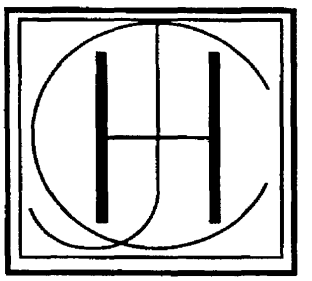
* Final Report on Study of Health Workforce Planning and Funding Mechanism *(Budget Item 12#3c)*
* Final Report on Long-Term Care Study
* Study of Regulation and Laws Relating to Midwifery *(SJR 196, Senator Edwards)*
* Report of the Commissioner of Health on Annual Review of COPN Program *(1997; HB 2477, Delegate Melvin)*

December 10, 10 A.M.

* Decision Matrix, Final Recommendations

January 6, 1999, 10 A.M.

* Sign Legislation



Joint Commission on Health Care
Old City Hall, Suite 115
1001 East Broad Street
Richmond, Virginia 23219
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

http://legis.state.va.us/jchc/jchchome.htm