REPORT OF THE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE ON

Plans Issued Pursuant to House Bill 2024 and Senate Bill 1141 (2009)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 12

COMMONWEALTH OF VIRGINIA
RICHMOND
2010

MARK C. CHRISTIE
COMMISSIONER

JAMES C. DIMITRI
COMMISSIONER

JUDITH WILLIAMS JAGDMANN
COMMISSIONER

COMMONWEALTH OF VIRGINIA

JOEL H. PECK
CLERK OF THE COMMISSION
P.O. BOX 1197
RICHMOND, VIRGINIA 23218-1197

STATE CORPORATION COMMISSION

August 2, 2010

To: The Honorable Robert F. McDonnell
Governor of Virginia
and
The General Assembly of Virginia

We are pleased to submit the Report of the State Corporation Commission on the Plans Issued Pursuant to House Bill 2024 and Senate Bill 1411 (2009).

Respectfully submitted,

James C. Dimitri
Chairman

Mark C. Christie
Commissioner

Judith Williams Jagdmann
Commissioner

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Introduction

House Bill 2024 was introduced in the 2009 Session of the General Assembly. Delegate Daniel W. Marshall, III was the chief patron of the bill. Similar legislation was introduced in the same legislative session by Senator John C. Watkins as Senate Bill 1411. The bills were passed by the General Assembly and the provisions relating to the plans discussed in this report became effective on July 1, 2009.

House Bill 2024 and Senate Bill 1411 were introduced to provide for the availability of "basic" health insurance in Virginia for small employers. The bills amended and reenacted § 32.1-102.4 in the Health Code to include provisions relating to the certificate of public need to allow for alternate methods of satisfying the conditions of a compliance plan. The bills added §§ 38.2-3406.1, 38.2-3406.2 and 38.2-3541.1 to the Insurance Code and amended and reenacted §§ 38.2-4214 and 38.2-4319 in the Health Services Plans and Health Maintenance Organizations (HMOs) chapters. House Bill 2024 also added §38.2-3541.1 relating to the continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The provision relating to COBRA coverage was effective on April 8, 2009.

The bills establish a plan of "basic health insurance coverage" that may be offered to small employers in Virginia. Essentially, with respect to these plans, insurers and health services plans may exclude one or more of the state-mandated benefits, except for those requiring coverage for mammograms, pap smears, PSA testing, and colorectal cancer screening (§§ 38.2-3418.1, 38.2-3418.1:2, 38.2-3418.7, and 38.2-3418.7:1, respectively). The bills also require that the plans provide for reimbursement to mandated providers listed in § 38.2-3408, for covered services that those providers may legally render in Virginia. The plans are commonly referred to as "mandate-lite" plans. With the exception of the four previously mentioned mandates, the plans may include none or all of the state-mandated benefits or mandated offers as the carrier and the insured agree.

The bills require those insurers and health services plans offering the mandate-lite plans to disclose prominently that the policy or contract is not required to provide state-mandated benefits, those state-mandated benefits that are not included in the plan, and eligibility requirements. The disclosures must be included in (1) the application and any enrollment

forms, (2) the policy form or subscription contract, and (3) certificate forms or other evidences of coverage that are furnished to each participant in each of the plans.

The bills also require those insurers and health services plans offering mandate-lite plans to report to the Bureau of Insurance annually on the number of small employers and individuals covered by the plans, the coverage provided, and the cost of premiums and out-of-pocket expenses. The Bureau of Insurance must compile the information and evaluate the impact of the plans and report to the Governor and the General Assembly on August 1, 2010 and August 1, 2011.

Subsequent legislation, House Bill 556, was introduced in the 2010 Session of the General Assembly by Delegate Daniel W. Marshall, III, to allow HMOs to provide mandate-lite plans. House Bill 556 was enacted by the General Assembly with a July 1, 2010 effective date.

Market Activity

The Bureau of Insurance surveyed the 38 carriers (insurers, health services plans, and HMOs) offering coverage in the small employer market in Virginia in May of 2010 to determine their marketing of, or intentions to market, mandate-lite plans in Virginia. Thirty-seven of the thirty-eight carriers responded to the survey by June 10, 2010.

The survey responses are summarized below:

3 Carriers Have Approved Mandate-Lite Plans

1 Carrier Plans to File a Mandate-Lite Plan for Approval in the Future

25 Carriers Have No Plans to Market Mandate-Lite Plans

8 Carriers Have Not Decided Whether To Market Mandate-Lite Plans

The remaining carrier did not respond to the survey by the extended deadline.

Of the three carriers with approved mandate-lite plans, one has not determined when or if it will market the plan. The carrier that offered the plans beginning March 1, 2010, had sold no plans as of May 1, 2010. The remaining carrier intends to begin offering the plans on July 1, 2010.

Coverage Offered Under Mandate-Lite Plans

The carriers that have approved mandate-lite plans intend to offer coverage for some of the state-mandated benefits that are otherwise not required by the mandate-lite provisions. One carrier includes coverage for hospice care and supplies for diabetes, and the other two carriers include coverage for childhood immunizations, infant hearing screening, supplies for diabetes, prosthetics, and hospice care.

The state-mandated benefits and mandated offers effective prior to July 1, 2010 are:

Dependent Children
Doctor to Include Dentist
Newborn Children
Child Health Supervision Services
Adopted Children
Childhood Immunizations
Infant Hearing Screening and Related Diagnostics
Mental Health and Substance Abuse Services
Biologically Based Mental Illness
Obstetrical Services
Obstetrical Benefits - Coverage for Postpartum Services
Conversion from Group to Individual Coverage
Coverage for Victims of Rape or Incest
Mammograms
Pap Smears
Procedures Involving Bones and Joints
Hemophilia and Congenital Bleeding Disorders
Reconstructive Breast Surgery

Early Intervention Services
Minimum Hospital Stay for Mastectomy
PSA Testing
Colorectal Cancer Screening
Clinical Trials for Treatment Studies on Cancer
Minimum Hospital Stay for Hysterectomy
Coverage for Diabetes
Hospice Care
Hospitalization and Anesthesia for Dental Procedures
Treatment of Morbid Obesity
Lymphedema
Prosthetic Devices and Components

Coverage for telemedicine will be required beginning July 1, 2010.

Premiums and Out-of-Pocket Expenses

Information on premiums, deductibles, co-payments and out-of-pocket maximums was requested on the survey of carriers in the small employer market. Information from the responses from three carriers is not a sufficient number to provide a meaningful average. Therefore, the information included here represents the highest and lowest amounts for each response.

The deductible amounts that are offered to employers for an individual range from $1,000 to $3,000 for in-network coverage and from $2,000 to $6,000 for out-of-network coverage. The options for deductibles for family coverage range from $2,000 to $6,000 for in-network coverage and from $6,000 to $12,000 for out-of-network coverage. Out-of-pocket maximums range from $4,000 to $12,000 for an individual. Out-of-pocket maximums for a family range from $8,000 to $24,000.

Although plans are available for groups of 2 to 50 employees, information on the estimated premium for the mandate-lite plans was supplied by all three carriers for a group of 2 to 14 employees. Information for the premium of other groups is not available from all of the carriers in the group bands. The estimated monthly premium for a group of 2 to 14 employees ranges

from approximately $300 to $430. The actual premium will be dependent on the deductible chosen and whether coverage for out-of-network providers is selected.

Two carriers will offer co-payments of $25 and $30. The other carrier will offer the mandate- lite product with a 30% co-insurance level for in-network coverage and 50% for out-of-network coverage.

Impact of the Mandate-Lite Plans

No mandate-lite plans were sold in Virginia by May 1, 2010. Only one carrier had a plan available for sale by that date. The majority of carriers in the small employer group market have indicated that they do not intend to offer the plans. However, the carriers that do have plans approved for sale, or intend to file a plan, are among the largest carriers in Virginia based on written accident and sickness insurance premiums. An additional eight carriers have not made a decision about offering the plans, but may market them in the future.

The relatively low number of carriers offering the plans could be due to the short time period since the sale of these plans has been allowed. The lack of sales may also be due to the availability of only one plan before survey responses were submitted. The legislation allowing the sale of mandate-lite products will have been in effect only 12 months as of July 1, 2010. The legislation that allows HMOs to offer the plans will not go into effect until July 1, 2010.

It is possible that up to 12 of the 38 carriers (32%) that are undecided and currently participate in the small employer market may subsequently offer the mandate-lite product. Alternately, the number of carriers with approved plans could remain 3 of the 38 (8%). It is not possible to determine the number of carriers that will enter or remain in the market at this time. It is also not possible to predict the attractiveness of the plans to small employers based on two months of the offering of only one mandate-lite plan.

In addition to the short time mandate-lite plans have been allowed in Virginia, the enactment of federal health care reform legislation is likely to have affected the number of carriers deciding to offer the plans at this time.

Conclusion

The health insurance marketplace is in a period of transition. There are numerous changes taking place at the present time because of the requirements and implementation of federal health care reforms under the Patient Protection and Affordable Care Act (Act). The federal legislation was passed on March 23, 2010. The provisions of the Act will be implemented over a period of years, and regulations and other federal guidance are not yet available for some provisions effective in 2010.

It is difficult to determine the future viability of mandate-lite products due to the uncertainty in the health insurance market in Virginia and other states. Another report on mandate-lite plans will be provided to the General Assembly in 2011. The regulatory and marketplace activity over the next 12 months will provide more information to allow for an assessment of the impact and prospective viability of mandate-lite plans.

CHAPTER 796

An Act to amend and reenact §§ 32.1-102.4, 38.2-4214, and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 38.2-3406.1, 38.2-3406.2, and 38.2-3541.1, relating to increasing the availability of basic health insurance coverage in the Commonwealth.

[H 2024]

Approved April 8, 2009

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-102.4, 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 38.2-3406.1, 38.2-3406.2, and 38.2-3541.1 as follows:

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

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

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

C. A certificate may be revoked when:

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

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

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

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

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

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

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

The certificate holder shall provide documentation to the Department demonstrating that the certificate holder has satisfied the conditions of the certificate. If the certificate holder is unable or fails to satisfy the conditions of a certificate, the Department may approve alternative methods to satisfy the conditions pursuant to a plan of compliance. The plan of compliance shall identify a timeframe within which the certificate holder will satisfy the conditions of the certificate, and identify how the certificate holder will satisfy the conditions of the certificate, which may include (i) making direct payments to an organization authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, (ii) making direct payments to a private nonprofit foundation that funds basic insurance coverage for indigents authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, or (iii) other documented efforts or initiatives to provide primary or specialized care to underserved

populations. In determining whether the certificate holder has met the conditions of the certificate pursuant to a plan of compliance, only such direct payments, efforts, or initiatives made or undertaken after issuance of the conditioned certificate shall be counted towards satisfaction of conditions.

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

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

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

A. As used in this section:

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

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

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

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

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

B. For the purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, and a group accident and sickness subscription contract providing health insurance coverage for eligible individuals, that is offered, sold, or issued by a health insurer to a small employer:

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

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

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

C. Any application and any enrollment form used in connection with coverage under this section shall prominently disclose that the policy or contract is not required to provide state-mandated health benefits, shall prominently disclose any and all state-mandated health benefits that the policy or subscription contract does not provide, and shall clearly describe all eligibility requirements.

D. A policy form or subscription contract issued under this section to a small employer shall prominently disclose any and all state-mandated health benefits that the policy or subscription contract does not provide. Such disclosure shall also be included in certificate forms or other evidences of coverage furnished to each participant. Health insurers proposing to issue forms providing coverage under this section shall clearly disclose the intended purposes for such policies or contracts when submitting the forms to the Commission for approval in accordance with § 38.2-316.

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

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

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

§ 38.2-3541.1. Continuation following involuntary termination of employment; special circumstances.

A. For purposes of meeting the definition of "COBRA continuation coverage" in Title III of Division B of the American Recovery and Reinvestment Act of 2009, P.L. 111-5 (the Act), employees who are involuntarily terminated during the period beginning September 1, 2008, and ending December 31, 2009, or during any period for which premium assistance is specified by the Act as later amended, shall be offered the option to continue their existing group health insurance coverage subject to the following:

1. Coverage shall continue for a period of up to nine months following the date of (i) involuntary termination for those terminated on or after the date of enactment of this section or (ii) following the date of the notification required pursuant to subdivision 3, contingent upon the involuntarily terminated employee's eligibility for premium assistance under the Act;

2. Premium payments (i) may be paid on a monthly basis to the group policyholder and (ii) shall not exceed 102 percent of the insurer's current premium rate applicable to the group policy;

3. Employers shall provide notification of the availability of continuation under this section as follows:

a. Notification shall be provided to those employees whose employment was terminated on or after September 1, 2008, and prior to February 17, 2009, in accordance with Section 3001 of the Act;

b. Notification shall be provided to those employees whose employment was terminated on or after February 17, 2009, and prior to the date of enactment of this section, no later than 60 days following the date of enactment of this section or the employee's termination, whichever is later; and

c. Notification shall be provided to those employees whose employment was terminated after the date of enactment of this section no later than 30 days following the date of the employee's termination;

4. The employee shall elect this continued coverage no later than 60 days following notification of plan enrollment options; and

5. All other provisions, restrictions and limitations contained in the Act shall apply.

B. The provisions of this section shall only apply to employees of small employers whose group health insurance coverage does not provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

C. As used in this section, "group health insurance coverage" and "health insurance issuer" shall have the same meaning as provided in § 38.2-3431.

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

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, *38.2-3406.1, 38.2-3406.2,* 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541, *38.2-3541.1,* 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall apply to the operation of a plan.

§ 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, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 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.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1, § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.14, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, *38.2-3541.1,* 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall 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. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 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.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, § 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6 and 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions 1, 2, and 3 of subsection F of § 38.2-3407.10, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, and 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 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.

C. 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.

D. 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.

E. 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.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

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

3. That health insurers offering plans pursuant to § 38.2-3406.1 of the Code of Virginia shall report annually to the Bureau of Insurance on the number of small employers and individuals using plans issued pursuant to such section, the coverage provided, and the cost of premiums and out-of-pocket expenses. The Bureau of Insurance shall compile this information and evaluate the impact of such plans in a report to be submitted to the Governor and General Assembly on August 1, 2010, and August 1, 2011.

4. That an emergency exists and the provision of this act amending the Code of Virginia by adding section numbered 38.2-3541.1 is in force from its passage.

VIRGINIA ACTS OF ASSEMBLY -- 2009 RECONVENED SESSION

CHAPTER 877

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

[S 1411]

Approved May 6, 2009

Be it enacted by the General Assembly of Virginia:

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

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

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

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

C. A certificate may be revoked when:

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

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

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

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

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

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

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

The certificate holder shall provide documentation to the Department demonstrating that the certificate holder has satisfied the conditions of the certificate. If the certificate holder is unable or fails to satisfy the conditions of a certificate, the Department may approve alternative methods to satisfy the conditions pursuant to a plan of compliance. The plan of compliance shall identify a timeframe within which the certificate holder will satisfy the conditions of the certificate, and identify how the certificate holder will satisfy the conditions of the certificate, which may include (i) making direct payments to an organization authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, (ii) making direct payments to a private nonprofit foundation that funds basic insurance coverage for indigents authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, or (iii) other documented efforts or initiatives to provide primary or specialized care to underserved

populations. In determining whether the certificate holder has met the conditions of the certificate pursuant to a plan of compliance, only such direct payments, efforts, or initiatives made or undertaken after issuance of the conditioned certificate shall be counted towards satisfaction of conditions.

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

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

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

A. As used in this section:

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

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

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

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

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care.

B. For purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, and a group accident and sickness subscription contract providing health insurance coverage for eligible individuals, that is offered, sold, or issued by a health insurer to a small employer:

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

a. Coverage for mammograms pursuant to § 38.2-3418.1,

b. Coverage for pap smears pursuant to § 38.2-3418.1:2,

c. Coverage for PSA testing pursuant to § 38.2-3418.7; and

d. Coverage for colorectal cancer screening pursuant to § 38.2-3418.7:1.

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

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

C. Any application and any enrollment form used in connection with coverage under this section shall prominently disclose that the policy or contract is not required to provide state-mandated health benefits and shall prominently disclose any and all state-mandated health benefits that the policy or subscription contract does not provide and shall clearly describe all eligibility requirements.

D. A policy form or subscription contract issued under this section to a small employer shall prominently disclose any and all state-mandated health benefits that the policy or subscription contract does not provide. Such disclosure shall also be included in certificate forms or other evidences of coverage furnished to each participant. Health insurers proposing to issue forms providing coverage under this section shall clearly disclose the intended purposes for such policies or contracts when submitting the forms to the Commission for approval in accordance with § 38.2-316.

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

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

Nothing in this chapter or Chapters 35 (§ 38.2-3500 et seq.) or 42 (§ 38.2-4200 et seq.) shall

prohibit the offering, sale, or issuance of accident and sickness insurance policies or subscription contracts that cap or limit the total annual or lifetime benefits provided under an accident and sickness insurance policy or subscription contracts at specified dollar amounts.

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

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

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

3. That health insurers offering plans pursuant to § 38.2-3406.1 of the Code of Virginia shall report annually to the Bureau of Insurance on the number of small employers and individuals using plans issued pursuant to such section, the coverage provided, and the cost of premiums and out-of-pocket expenses. The Bureau of Insurance shall compile this information and evaluate the impact of such plans in a report to be submitted to the Governor and General Assembly on August 1, 2010, and August 1, 2011.