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HOUSE BILL NO. 2601

Offered January 8, 2003

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A BILL to amend and reenact §§ 38.2-4300, 38.2-4302, 38.2-4303, and 38.2-4306 of the Code of Virginia, relating to health maintenance organizations; powers.

Patrons—Bryant, Byron, Griffith and Morgan; Senators: Wagner and Wampler

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4300, 38.2-4302, 38.2-4303, and 38.2-4306 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-4300. Definitions.

As used in this chapter:

"Acceptable securities" means securities that (i) are legal investments under the laws of this Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, (iii) have a current market value of not less than $50,000 nor more than $500,000, and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership effected on the records of the depository and its participants pursuant to rules and procedures established by the depository.

"Basic health care services" means in and out-of-area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, and preventive health services. "Basic health care services" shall also mean limited treatment of mental illness and substance abuse in accordance with such minimum standards as may be prescribed by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) of this title. In the case of a health maintenance organization that has contracted with this Commonwealth to furnish basic health services to recipients of medical assistance under Title XIX of the United States Social Security Act pursuant to § 38.2-4320, the basic health services to be provided by the health maintenance organization to program recipients may differ from the basic health services required by this section to the extent necessary to meet the benefit standards prescribed by the state plan for medical assistance services authorized pursuant to § 32.1-325.

"Copayment" means ~~a payment required of enrollees as a condition of the receipt of~~*an amount an enrollee is required to pay in order to receive a* specific health ~~services~~*care service*.

"Deductible" means an amount an enrollee is required to pay out-of-pocket before the health care plan begins to pay the costs associated with health care services.

"Emergency services" means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate, individual or group agreement or contract, or identification card issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Excess insurance" or "stop loss insurance" means insurance issued to a health maintenance organization by an insurer licensed in this Commonwealth, on a form approved by the Commission, or a risk assumption transaction acceptable to the Commission, providing indemnity or reimbursement against the cost of health care services provided by the health maintenance organization.

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, including emergency services and services rendered by nonparticipating referral providers, as distinguished from mere

indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a significant part shall mean at least ninety percent of total costs of health care services.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"Limited health care services" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, and such other services as may be determined by the Commission to be limited health care services. Limited health care services shall not include hospital, medical, surgical or emergency services except as such services are provided incident to the limited health care services set forth in the preceding sentence.

"Net worth" means the excess of total admitted assets over the total liabilities of the health maintenance organization, provided that surplus notes shall be reported and accounted for in accordance with guidance set forth in the National Association of Insurance Commissioners (NAIC) accounting practice and procedures manuals.

"Nonparticipating referral provider" means a provider who is not a participating provider but with whom a health maintenance organization has arranged, through referral by its participating providers, to provide health care services to enrollees. Payment or reimbursement by a health maintenance organization for health care services provided by nonparticipating referral providers may exceed five percent of total costs of health care services, only to the extent that any such excess payment or reimbursement over five percent shall be combined with the costs for services which represent mere indemnification, with the combined amount subject to the combination of limitations set forth in this definition and in this section's definition of health care plan.

"Participating provider" means a provider who has agreed to provide health care services to enrollees and to hold those enrollees harmless from payment with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the health maintenance organization.

"Provider" or "health care provider" means any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services.

"Subscriber" means a contract holder, an individual enrollee or the enrollee in an enrolled family who is responsible for payment to the health maintenance organization or on whose behalf such payment is made.

§ 38.2-4302. Issuance of license; fee; minimum net worth; impairment.

A. The Commission shall issue a license to a health maintenance organization after the receipt of a complete application and payment of a $500 nonrefundable application fee if the Commission is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and reputable;

2. The health care plan constitutes an appropriate mechanism for the health maintenance organization to provide or arrange for the provision of, as a minimum, basic health care services or limited health care services on a prepaid basis, except to the extent of reasonable requirements for copayments, *deductibles, or both*;

3. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commission may consider:

a. The financial soundness of the health care plan's arrangements for health care services and the schedule of prepaid charges used for those services;

b. The adequacy of working capital;

c. Any agreement with an insurer, a health services plan, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage if the health care plan is discontinued;

d. Any contracts with health care providers that set forth the health care services to be performed and the providers' responsibilities for fulfilling the health maintenance organization's obligations to its enrollees;

e. The deposit of acceptable securities in an amount satisfactory to the Commission, submitted in accordance with § 38.2-4310 as a guarantee that the obligations to the enrollees will be duly performed;

f. The applicant's net worth which shall include minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than $600,000, up to a maximum of $4 million; uncovered expenses shall be amounts determined from the most recently ended calendar quarter pursuant to regulations promulgated by the Commission; and

g. A financial statement of the health maintenance organization on the form required by § 38.2-4307;

4. The enrollees will be given an opportunity to participate in matters of policy and operation as required by § 38.2-4304; and

5. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-4301 or Chapter 58 (§ 38.2-5800 et seq.) or by independent investigation. Issuance of a license shall not constitute approval of the forms submitted under subdivisions 5, 6, and 11 of subsection B of § 38.2-4301.

B. A licensed health maintenance organization shall have and maintain at all times the minimum net worth described in subdivision 3 f of subsection A of this section.

1. If the Commission finds that the minimum net worth of a domestic health maintenance organization is impaired, the Commission shall issue an order requiring the health maintenance organization to eliminate the impairment within a period not exceeding ninety days. The Commission may by order served upon the health maintenance organization prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If at the expiration of the designated period the health maintenance organization has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the health maintenance organization may be entered as provided in § 38.2-4317.

2. If the Commission finds an impairment of the minimum net worth of any foreign health maintenance organization, the Commission may order the health maintenance organization to eliminate the impairment and restore the minimum net worth to the amount required by this section. The Commission may, by order served upon the health maintenance organization, prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If the health maintenance organization fails to comply with the Commission's order within a period of not more than ninety days, the Commission may, in the manner set out in § 38.2-4316, suspend or revoke the license of the health maintenance organization.

3. Prior to December 31, 1999, a health maintenance organization with less than minimum net worth which is licensed on and after June 30, 1998, may continue to operate as a licensed health maintenance organization without a finding of impairment if the licensee has net worth (i) on June 30, 1998, and up to December 31, 1998, in an amount at least equal to the sum of uncovered expenses, but not less than $300,000, up to a maximum of $2 million; (ii) on December 31, 1998, and up to June 30, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $400,000, up to a maximum of $2.5 million; and (iii) on June 30, 1999, and up to December 31, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $500,000, up to a maximum of $3 million.

§ 38.2-4303. Powers.

A. The powers of a health maintenance organization shall include, but shall not be limited to, the following, provided that the activities comply with all applicable state statutes and regulations:

1. The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical or other health care facilities, and their ancillary equipment and other property reasonably required for its principal office or for other purposes necessary in the transaction of the business of the organization;

2. The making of loans to (i) health care providers under contract with it in advancement of its health care plan or (ii) any corporation under its control for the purpose of acquiring or constructing medical or other health care facilities and hospitals or in advancement of its health care plan providing health care services to enrollees;

3. The furnishing of health care services through providers that are under contract with or employed by the health maintenance organization;

4. The contracting with any person for the performance on its behalf of certain functions including, but not limited to, marketing, enrollment and administration;

5. The contracting with an insurer or with a health services plan licensed in this Commonwealth, for the provision of insurance, indemnity, or reimbursement for the cost of health care services provided by the health maintenance organization;

6. The offering, in addition to basic health care services, of:

a. Additional health care services;

b. Indemnity benefits covering out-of-area services; and

c. Indemnity benefits, in addition to those relating to out-of-area services, provided through insurers or health services plans~~;~~ ~~and~~

7. The offering of health care plans for limited health care services*; and*

8. The requirement for the enrollee to pay a reasonable deductible or copayment, or both, for any health care services offered pursuant to this Chapter, provided that the total deductible or deductibles for basic health care services per calendar year or contract year shall not exceed the maximum annual deductibles permissible for health plans offered in conjunction with plans made available pursuant to 26 U.S.C. 220 or any successor thereto. If the federal program for these plans is terminated, the health care plan may offer plans with deductibles that do not exceed those permitted for the last year in which the federal program was in effect plus $50 per calendar year thereafter. In determining whether a health care plan's deductibles are unreasonable, the Commission may consider at least the following

criteria:

a. Whether the deductibles will adversely affect accessibility to health care services among the health care plan's enrollees in the Commonwealth;

b. Whether the health care plan has demonstrated its ability to monitor and implement the deductible plans; and

c. Whether the health care plan's level of capitalization and financial condition are adequate to support the deductible plans.

B. 1. A health maintenance organization shall file notice with the Commission within thirty days after the exercise of any power granted in subdivision 1 or 2 of subsection A of this section that exceeds one percent of the admitted assets of the organization or five percent of net worth, whichever is less. A health maintenance organization shall file notice, with adequate supporting information, with the Commission prior to the exercise of any power granted in subdivision 1 or 2 of subsection A of this section that exceeds five percent of the admitted assets of the organization or twenty-five percent of net worth, whichever is less. Any series of transactions occurring within a twelve-month period that are sufficiently similar in nature to be reasonably construed as a single transaction shall be subject to the limitations set forth in this section. The Commission shall disapprove the exercise of power if the Commission believes such exercise of power would substantially and adversely affect the financial soundness of the health maintenance organization and endanger the health maintenance organization's ability to meet its obligations. If the Commission does not disapprove the exercise of power within thirty days of the filing, it shall be deemed approved.

2. Upon application by the health maintenance organization, the Commission may exempt from the filing requirement of subdivision 1 of subsection B of this section those activities having a minimal effect.

§ 38.2-4306. Evidence of coverage and charges for health care services.

A. 1. Each subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the Commission, subject to the provisions of subsection C of this section.

3. No evidence of coverage shall contain provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.

4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

a. The health care services and any insurance or other benefits to which the enrollee is entitled under the health care plan;

b. Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature, *or both*;

c. Where and in what manner information is available as to how services may be obtained;

d. The total amount of payment for health care services and any indemnity or service benefits that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory for group certificates;

e. A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee;

f. A list of providers and a description of the service area which shall be provided with the evidence of coverage, if such information is not given to the subscriber at the time of enrollment; and

g. The right of subscribers covered under a group contract to convert their coverages to an individual contract issued by the health maintenance organization.

B. 1. No schedule of charges or amendment to the schedule of charges for enrollee coverage for health care services may be used in conjunction with any health care plan until a copy of the schedule, or its amendment, has been filed with the Commission.

2. The charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applying to an enrollee in a group health plan shall not be individually determined based on the status of his health. A certification on the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information. This certification shall be prepared by a qualified actuary or other qualified professional approved by the Commission.

C. The Commission shall, within a reasonable period, approve any form if the requirements of subsection A of this section are met. It shall be unlawful to issue a form until approved. If the Commission disapproves a filing, it shall notify the filer. The Commission shall specify the reasons for its disapproval in the notice. A written request for a hearing on the disapproval may be made to the Commission within thirty days after notice of the disapproval. If the Commission does not disapprove any form within thirty days of the filing of such form, it shall be deemed approved unless the filer is notified in writing that the waiting period is extended by the Commission for an additional thirty days.

Filing of the form means actual receipt by the Commission.

D. The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing made under this section.