VIRGINIA ACTS OF ASSEMBLY -- 2004 SESSION

CHAPTER 715

An Act to amend and reenact §§ 38.2-3407.10 and 38.2-5803 of the Code of Virginia, relating to health insurance provider panels.

[S 618]

Approved April 12, 2004

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3407.10 and 38.2-5803 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3407.10. Health care provider panels.

A. As used in this section:

"Carrier" means:

1. Any 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;

2. Any corporation providing individual or group accident and sickness subscription contracts;

3. Any health maintenance organization providing health care plans for health care services;

4. Any corporation offering prepaid dental or optometric services plans; or

5. Any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

"Enrollee" means any person entitled to health care services from a carrier.

"Provider" means a hospital, physician or any type of provider licensed, certified or authorized by statute to provide a covered service under the health benefit plan.

"Provider panel" means those providers with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan. However, such term does not include an arrangement between a carrier and providers in which any provider may participate solely on the basis of the provider's contracting with the carrier to provide services at a discounted fee-for-service rate.

B. Any such carrier that offers a provider panel shall establish and use it in accordance with the following requirements:

1. Notice of the development of a provider panel in the Commonwealth or local service area shall be filed with the Department of Health Professions.

2. Carriers shall provide a provider application and the relevant terms and conditions to a provider upon request.

C. A carrier that uses a provider panel shall establish procedures for:

1. Notifying an enrollee of:

a. The termination from the carrier's provider panel of the enrollee's primary care provider who was furnishing health care services to the enrollee; and

b. The right of an enrollee upon request to continue to receive health care services for a period of up to ~~ninety~~ *90* days from the date of the primary care provider's notice of termination from a carrier's provider panel, except when a provider is terminated for cause.

2. Notifying a provider at least ~~ninety~~ *90* days prior to the date of the termination of the provider, except when a provider is terminated for cause.

3. Providing reasonable notice to primary care providers in the carrier's provider panel of the termination of a specialty referral services provider.

4. Notifying the purchaser of the health benefit plan, whether such purchaser is an individual or an employer providing a health benefit plan, in whole or in part, to its employees and enrollees of the health benefit plan of:

a. A description of all types of payment arrangements that the carrier uses to compensate providers for health care services rendered to enrollees, including, but not limited to, withholds, bonus payments, capitation and fee-for-service discounts; and

b. The terms of the plan in clear and understandable language ~~which~~ *that* reasonably informs the purchaser of the practical application of such terms in the operation of the plan.

D. Whenever a provider voluntarily terminates his contract with a carrier to provide health care services to the carrier's enrollees under a health benefit plan, he shall furnish reasonable notice of such termination to his patients who are enrollees under such plan.

E. A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of gender, race, age, religion or national origin.

F. 1. For a period of at least ~~ninety~~ *90* days from the date of the notice of a provider's termination from the carrier's provider panel, except when a provider is terminated for cause, the provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees who:

a. Were in an active course of treatment from the provider prior to the notice of termination; and

b. Request to continue receiving health care services from the provider.

2. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who has entered the second trimester of pregnancy at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the enrollee's option, continue through the provision of postpartum care directly related to the delivery.

3. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who is determined to be terminally ill (as defined under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the enrollee's option, continue for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

4. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

G. 1. A carrier shall provide to a purchaser ~~prior to~~ *upon* enrollment and make available to existing enrollees at least once a year a list of members in its provider panel, which list shall also indicate those providers who are not currently accepting new patients. Such list ~~for existing enrollees~~ may be made available ~~by notifying such enrollees about how they may~~ *in a form other than a printed document, provided the purchaser or existing enrollee is given the means to* request *and receive* a printed copy of ~~the~~ *such* list ~~from the carrier and notifying them of other means of access to the list, including Internet access~~.

2. The information provided under subdivision 1 shall be updated at least once a year *if in paper form, and monthly if in electronic form.*

H. No contract between a carrier and a provider may require that the provider indemnify the carrier for the carrier's negligence, willful misconduct, or breach of contract, if any.

I. No contract between a carrier and a provider shall require a provider, as a condition of participation on the panel, to waive any right to seek legal redress against the carrier.

J. No contract between a carrier and a provider shall prohibit, impede or interfere in the discussion of medical treatment options between a patient and a provider.

K. A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

L. Any carrier requiring preauthorization for medical treatment shall have personnel available to provide such preauthorization at all times when such preauthorization is required.

M. Carriers shall provide to their group policyholders written notice of any benefit reductions during the contract period at least ~~sixty~~ *60* days before such benefit reductions become effective. Group policyholders shall, in turn, provide to their enrollees written notice of any benefit reductions during the contract period at least ~~thirty~~ *30* days before such benefit reductions become effective. Such notice shall be provided to the group policyholder as a separate and distinct notification, and may not be combined with any other notification or marketing materials.

N. No contract between a provider and a carrier shall include provisions ~~which~~ *that* require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions.

O. If a provider panel contract between a provider and a carrier, or other entity that provides hospital, physician or other health care services to a carrier, includes provisions that require a provider, as a condition of participating in one of the carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that carrier or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more such other provider panels at the time the contract is executed. If a provider contracts with a carrier or other entity that subsequently contracts with one or more unaffiliated carriers to include such provider in the provider panels of such unaffiliated carriers, and which permits an unaffiliated carrier to impose participation terms with respect to such provider that differ materially in reimbursement rates or in managed care procedures, such as conducting economic profiling or requiring a patient to obtain primary care physician referral to a specialist, from the terms agreed to by the provider in the original contract, the provider panel contract shall contain a provision permitting the provider to refuse participation with any such unaffiliated carrier. Utilization review pursuant to Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not constitute a materially different managed care procedure. This subsection shall apply to provider panels utilized by health maintenance organizations and preferred provider organizations. For purposes of this subsection, "preferred provider organization" means a carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209. The status of a physician as a member of or as being eligible for other existing or new provider panels shall not be adversely affected by the exercise of such right to refuse participation. This subsection shall not apply to the Medallion II and children's health insurance plan administered by or

pursuant to contract with the Department of Medical Assistance Services.

P. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

Q. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on or after July 1, 1996. However, the ~~ninety~~ *90*-day period referred to in subdivisions C 1 b and C 2 of this section, the requirements set forth in subdivisions F 2 and F 3, and the requirements set forth in subsections L, M, and N shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1999, and the requirements set forth in subsection O shall apply to contracts between carriers and providers that are entered into, reissued, extended or renewed on or after July 1, 2001.

§ 38.2-5803. Disclosures and representations to enrollees.

A. The following shall be provided to the MCHIP's covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and shall be made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers. *Such list may be made available in a form other than a printed document, provided the purchaser or existing enrollee is given the means to request and receive a printed copy of such list.*

2. A description of the service area or areas within which the MCHIP shall provide health care services.

3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.

4. Notice that the MCHIP is subject to regulation in ~~this~~ *the* Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice included within the evidence of coverage, providing substantially the following: "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided ~~which~~ *that* have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance." Such notice shall also provide the toll-free telephone number, mailing address, and electronic mail address of the Office of the Managed Care Ombudsman.

B. The following shall apply to MCHIPs that require a covered person to select a primary care physician with respect to the offer of basic health care services by the MCHIP:

1. At the time of enrollment each covered person shall have the right to select a primary care physician from among the health carrier's affiliated primary care physicians for the MCHIP, subject to availability.

2. Any covered person who is dissatisfied with his primary care physician shall have the right to select another primary care physician from among the affiliated primary care physicians, subject to availability. The health carrier may impose a reasonable waiting period for this transfer.