VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 38.2-4306 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-4320.1, relating to health maintenance organizations providing services to enrollees covered by medical assistance services or the Family Access to Medical Insurance Security (FAMIS) Plan; emergency.

[H 628]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4306 of the Code of Virginia is amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-4320.1 as follows:

§ 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~~ *Any* right of subscribers covered under a group contract to convert their coverages to an individual contract issued by the health maintenance organization. *In addition to any exceptions from the requirement of this subdivision that may be specified in regulations adopted by the Commission, no conversion contract right upon termination shall be required for enrollees in the 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.*

B. *Pursuant to this subsection:*

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 30 days after notice of the disapproval. If the Commission does not disapprove any form within 30 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 30 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.

§ 38.2-4320.1. Explanation of benefits for health maintenance organization enrollees who are recipients of medical assistance services or covered by the Family Access to Medical Insurance Security (FAMIS) Plan.

In the case of any health maintenance organization that has contracted with the Virginia Department of Medical Assistance Services to provide health care services to recipients of medical assistance services pursuant to Title XIX of the Social Security Act, as amended, or to individuals who are covered by the Family Access to Medical Insurance Security (FAMIS) Plan developed pursuant to Title XXI of the Social Security Act, as amended, the requirements for furnishing an explanation of benefits to current or former members and their respective health care providers shall be as authorized and directed in the standards prescribed in the state plan for medical assistance services pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and the FAMIS Plan pursuant to Chapter 13 (§ 32.1-351 et seq.) of Title 32.1. The requirements for an explanation of benefits otherwise addressed in this title shall not apply to such health maintenance organization when contracting to deliver such services to the extent that the statutory requirements differ from the standards of the Department of Medical Assistance Services.

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