VIRGINIA ACTS OF ASSEMBLY -- 2006 SESSION

CHAPTER 866

An Act to amend and reenact §§ 38.2-1318, 38.2-4306, 38.2-4319, 38.2-5803, and 38.2-5804 of the Code of Virginia, relating to regulation of Medicaid coverages provided by health maintenance organizations; accident and sickness policies.

[H 1041]

Approved April 19, 2006

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-1318, 38.2-4306, 38.2-4319, 38.2-5803, and 38.2-5804 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-1318. Examinations; how conducted.

A. Whenever the Commission examines the affairs of any person, as set forth in § 38.2-1317, it may appoint as examiners one or more competent persons.

1. To the extent practicable, the examiners shall be regular employees of the Commission.

2. No examiner may be appointed by the Commission if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this article; however, this section shall not be construed to automatically preclude an examiner from being:

a. A policyholder or claimant under an insurance policy;

b. A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

c. An investment owner in shares of regulated diversified investment companies; or

d. A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

3. Notwithstanding the requirements of this subsection, the Commission may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals or firms who are independently practicing their professions, even though said persons may from time to time be similarly employed or retained by persons subject to examination under this article.

B. The examiners shall be instructed as to the scope of the examination, and, in conducting the examination, the examiner shall observe, to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook, or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate.

C. Every company or person from whom information is sought, its officers, directors, and agents shall provide the examiners convenient access at all reasonable hours to its books, records, files, securities, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined or those of any person, including any affiliates or subsidiaries of the person examined, that are relevant to the examination.

1. The officers, directors, employees and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so.

2. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the company to engage in an insurance or other business subject to the Commission's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to § 38.2-1040.

D. For the purpose of any investigation or proceeding under this article, the Commission or any individual designated by it may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of any books, papers, correspondence, memoranda, agreements or other documents or records which the Commission determines are relevant to the examination.

E. In connection with any examination, the Commission may retain attorneys, appraisers, independent actuaries, independent certified public accountants, security analysts or other professionals and specialists as examiners; the cost of which shall be borne by the company which is the subject of the examination.

F. Nothing contained in this article shall be construed to limit the Commission's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the provisions of this title.

G. Nothing contained in this article shall be construed to limit the Commission's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commission may deem

appropriate.

H. Whenever the Commission examines the affairs of any person providing benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, as set forth in § 38.2-1317, nothing contained in this article shall be construed to limit the Commission's authority to consult with the Department of Medical Assistance Services about such person before taking any action as a result of services the person provides pursuant to Title XIX or Title XXI of the Social Security Act, as amended.

§ 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. *Any evidence of coverage 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, is excluded from the provisions 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. 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. *Any schedule of charges or amendment to the schedule of charges 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, is excluded from the provisions of this subsection.*

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.

§ 38.2-4319. 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.),

§§ 38.2-1017 through 38.2-1023, 38.2-1057, 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, §§ 38.2-1800 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, 38.2-3542, 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 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.), §§ 38.2-1017 through 38.2-1023, 38.2-1057, 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 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.09:02, 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 through 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.

~~C~~ *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.

~~D~~ *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.

~~E~~ F. For purposes of applying this section, "insurer" when used in a section cited in ~~subsection~~ *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.

§ 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 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 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. *This section shall not apply to evidences of coverage 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. 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.

§ 38.2-5804. Complaint system.

A. A health carrier subject to subsection B of § 38.2-5801 shall establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints in accordance with requirements in or established pursuant to provisions in this title and Title 32.1 and shall include the following:

1. A record of the complaints shall be maintained for no less than five years.

2. Such health carrier shall provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone number of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman, and shall also specify any required limits imposed by or on behalf of the MCHIP. Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions pursuant to § 32.1-137.15.

B. The Commission, in cooperation with the State Health Commissioner, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this chapter shall be assessed by the State Health Commissioner pursuant to provisions in Title 32.1 and the regulations promulgated thereunder. Compliance by the health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of this title, shall be assessed by the Commission.

C. The health carrier for each MCHIP shall submit to the Office of the Managed Care Ombudsman and the State Health Commissioner an annual complaint report in a form prescribed by the Commission and the Board of Health. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the grievance or complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the MCHIP's affiliated providers.

D. *The provisions of this section shall not apply to 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.*

E. The provisions of Chapter 5 (§ 38.2-500 et seq.) of this title shall apply to the health carrier, its MCHIPs, and evidence of coverage and representations thereto, except to the extent that the Commission determines that the nature of the health carrier, its MCHIP, and evidences of coverage and representations thereto render any of the provisions clearly inappropriate.