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HOUSE BILL NO. 250

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on February 25, 2008)

(Patron Prior to Substitute—Delegate O'Bannon)

A BILL to amend and reenact §§ 2.2-2101, as it is currently effective and as it may become effective, 38.2-3407.12, 38.2-5801, and 38.2-5802 of the Code of Virginia and to amend the Code of Virginia by adding in Article 6 of Chapter 2 of Title 2.2 sections numbered 2.2-214.2 through 2.2-214.11 and by adding in Chapter 58 of Title 38.2 an article numbered 2, consisting of sections numbered 38.2-5812 through 38.2-5820, relating to the managed care health insurance plans.

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2101, as it is currently effective and as it may become effective, 38.2-3407.12, 38.2-5801, and 38.2-5802 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 6 of Chapter 2 of Title 2.2 sections numbered 2.2-214.2 through 2.2-214.11 and by adding in Chapter 58 of Title 38.2 an article numbered 2, consisting of sections numbered 38.2-5812 through 38.2-5820, as follows:

§ 2.2-214.2. Secretary of Health and Human Resources to establish Small Employer Managed Care Health Insurance Program.

There is hereby established under the supervision of the Secretary of Health and Human Resources, in collaboration with the Commissioner of Insurance, the Small Employer Managed Care Health Insurance Program (the Program). The purpose of the Program shall be to provide health insurance premium assistance to allow eligible low-income working individuals to purchase health insurance coverage through a Certified Small Employer Managed Care Health Insurance Policy.

§ 2.2-214.3. Definitions.

As used in this chapter, unless the context requires otherwise or it is otherwise provided:

"Board" means the Small Employer Managed Care Health Insurance Program Board.

"Certified Small Employer Managed Care Health Insurance Policy" means a health insurance policy offered by an insurer authorized to operate a managed care health insurance plan pursuant to Article 2 (§ 38.2-5812 et seq.) of Chapter 58 of Title 38.2, that has been certified by the Board, for which individuals employed by qualified small employers may qualify for premium assistance as authorized by this chapter.

"Federal poverty level" means the poverty level promulgated and periodically updated by the U.S. Department of Health and Human Services in the Federal Register, under the authority of 42 U.S.C. 9902(2).

"Program" means the Small Employer Managed Care Health Insurance Program.

"Qualified small employer" means an employer located in Virginia that employed at least two but not more than 50 employees on business days during the preceding calendar year and that has not offered health insurance to its employees during the six months prior to applying for participation in the Small Employer Managed Care Health Insurance Program.

§ 2.2-214.4. Small Employer Managed Care Health Insurance Program Board.

A. There is hereby established the Small Employer Managed Care Health Insurance Board as a policy board within the meaning of § 2.2-2100, in the executive branch of state government. The Board shall consist of 13 residents of the Commonwealth, as follows: the Secretary of Health and Human Resources shall be a member and shall serve as Chairman of the Board; five members appointed by the Governor, including two members who represent health insurance companies, one member who represents insurance brokers and agents, one member who represents small businesses, and one member who represents health care providers; three members appointed by the Speaker of the House of Delegates, including one member of the House of Delegates, one member who represents the Virginia Chamber of Commerce, and one member who represents health insurance consumers; two members appointed by the Senate Committee on Rules, including one member of the Senate of Virginia and one member representing small businesses; the Commissioner of the State Corporation Commission's Bureau of Insurance or his designee and the Director of the Department of Medical Assistance Services shall serve as ex officio members without voting privileges.

B. After the initial staggering of terms, all appointments shall be for four years, except that appointments to fill vacancies shall be made for the unexpired terms.

C. The Board shall meet as necessary and at such time and location as agreed by the Board. A majority of the members shall constitute a quorum. The Board shall conduct its business in accordance with the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). Notwithstanding the provisions of § 2.2-2825, the members shall not receive compensation for their services nor reimbursement for

expenses incurred in the discharge of their duties.

D. The Board shall promulgate regulations to implement the provisions of this chapter in accordance with the Administrative Process Act (§ 2.2-4000 et seq.).

E. The Board shall issue an annual report on the status of the Program to the Governor and the chairmen of the House Appropriations and Senate Finance Committees no later than May 1 of each year. The report shall include information on the operation and administration of the Program including, but not limited to, (i) the number of participating qualified small employers, (ii) the number of individuals covered under the Program, (iii) the number of covered individuals exceeding the claims threshold, (iv) the number of small employers denied participation in the Program, (v) the status of the Small Employer Managed Care Health Insurance Program Fund, as established in § 2.2-214.10, and (vi) any issues related to the Program that may need to be addressed.

§ 2.2-214.5. Powers and duties of the Board.

A. The Board shall promulgate regulations to implement the provisions of this chapter. Such regulations shall include a procedure for paying the premium contributions from qualified small employers and eligible individuals, along with the premium assistance authorized by this chapter to the insurer, in a manner that gives constant coverage to the eligible individuals.

B. The Board shall establish a process for the certification of small employer managed care health insurance plans and Small Employer Managed Care Health Insurance Policies developed pursuant to Article 2 (§ 38.2-5812 et seq.) of Chapter 34 of Title 38.2. In certifying such plans, the Board may:

1. Specify minimum requirements with respect to the health benefits to be covered by the program, which shall prioritize preventive health services. The Board shall consider requiring the program to cover generic prescription drugs and physician visits with limited cost-sharing. The Board may permit limitations on the amount of such services covered by the program and may permit increased cost-sharing at higher utilization levels;

2. Establish incentives for the development of benefit packages emphasizing preventive and primary care;

3. Specify requirements with respect to program coverage of dependents of eligible individuals. The Board may establish separate premium contribution levels for the state, employers, and employees with respect to dependent coverage;

4. Specify requirements with respect to the coverage of maternity services;

5. Specify requirements with respect to exclusions of preexisting conditions, provided that no preexisting condition provision subjects an eligible individual to a preexisting condition exclusion period greater than 12 months;

6. Specify requirements with respect to eligible individual cost-sharing;

7. Specify a maximum policy year claims threshold;

8. Specify requirements with respect to the application and enrollment process;

9. Specify requirements with respect to continuing coverage for eligible individuals who leave employment of a qualified small employer;

10. Specify applicable marketing guidelines, including the use of an existing commercial brokerage or agent network;

11. Specify applicable reporting requirements of insurers;

12. Allow for the establishment of premium discounts for healthy behaviors, including abstaining from tobacco use and maintaining a healthy body mass index; and

13. Include any other requirements or incentives the Board deems appropriate.

C. The Board may enter into contracts with one or more insurers selected through a competitive bidding process to provide Certified Small Employer Managed Care Health Insurance Policies to eligible individuals.

D. On an annual basis, the Board shall determine the Commonwealth's maximum premium assistance amount for eligible individuals, including for any dependent coverage.

E. The Board is authorized to apply for and accept grant funding, including funds authorized by the federal government; receive gifts or bequests from any private person or other organization; and deposit such funds into the Small Employer Managed Care Health Insurance Program Fund established in § 2.2-214.10.

§ 2.2-214.6. Secretary of Health and Human Resources to administer.

A. The Secretary of Health and Human Resources, in collaboration with the Commissioner of Insurance, shall administer the Program in accordance with the regulations promulgated by the Board.

B. The finances, assets, liabilities, and administrative costs and all other financial transactions of the Program shall be maintained and accounted for separately from any other funds that may be administered by the Secretary of Health and Human Resources.

§ 2.2-214.7. Small Employer Managed Care Health Insurance Program.

A. The Small Employer Managed Care Health Insurance Program shall provide monthly health insurance premium assistance on behalf of low-income individuals who are employed by a qualified

small employer. Such payments shall be made only on behalf of individuals determined eligible for the Program pursuant to § 2.2-214.8, and who are enrolled in or insured under a Certified Small Employer Managed Care Health Insurance Policy.

B. No insurer shall offer or market any insurance product as a Certified Small Employer Managed Care Health Insurance Policy without first receiving prior written approval by the Board. Insurers desiring to sell a Certified Small Employer Managed Care Health Insurance Policy shall submit information and documentation as required by the Board such that the Board can determine that the proposed policy meets the requirements for being a Certified Small Employer Managed Care Health Insurance Policy. Such information shall be submitted in the manner and format established by the Board.

C. The monthly premium assistance paid by the Program shall be equal to one-third of the total monthly premium for an eligible employee enrolled in or insured under a Certified Small Employer Managed Care Health Insurance Policy up to a maximum of $75 per month. Of the remaining monthly premium amount, at least one-half shall be paid by the insured individual's qualified small employer, and the remaining amount shall be paid by the insured individual. Should the $75 maximum payment be less than one-third of the total monthly premium, the qualified small employer shall pay a minimum of one third of the monthly premium amount.

D. Insurers who enroll eligible individuals into a Certified Small Employer Managed Care Health Insurance Policy shall submit documentation to the Program in the manner and format established by the Board in order to receive the Small Employer Managed Care Health Insurance Program premium assistance as provided in this chapter. The Program shall ensure that all applicable requirements of this chapter and any applicable requirements contained in regulations promulgated by the Board are satisfied prior to paying the premium assistance.

E. Insurers participating in the Program shall be subject to audit as required by the Secretary of Health and Human Resources to ensure proper administration, reporting, and accounting of Program premium assistance payments.

F. The Board shall ensure, to the greatest extent possible, that coverage under this program does not substitute for existing commercial health insurance coverage available in the Commonwealth.

§ 2.2-214.8. Eligibility.

A. In order to be eligible for the Program an individual shall (i) be a resident of Virginia; (ii) have a family income that is at or below 200 percent of the federal poverty level; (iii) have not been insured or had the offer of insurance within six months prior to enrollment in the Program; (iv) be ineligible for full-benefit medical assistance pursuant to Title XIX of the Social Security Act, as amended, or benefits pursuant to Title XXI of the Social Security Act, as amended; (v) be ineligible for coverage issued pursuant to Title XVIII of the Social Security Act, as amended, or under 10 U.S.C. § 1071 (TriCare/CHAMPUS), as amended; (vi) be employed by a qualified small employer; and (vii) work at least 30 hours per week for the qualified small employer.

B. Individuals who meet all of the requirements of subsection A except for subdivision (ii) shall be eligible for coverage under a Certified Small Employer Managed Care Health Insurance Policy; however, the entire monthly premium for such individuals shall be paid by the individual and the individual's qualified small employer, with the qualified small employer paying a minimum of one third of the monthly premium. No premium assistance shall be paid by the Commonwealth on behalf of such individuals.

§ 2.2-214.9. No entitlement to coverage.

This chapter shall not be construed as creating any legally enforceable right or entitlement to benefits under the Program on the part of any person or any right or entitlement to participation. The Program shall approve and process monthly premium assistance payments only to the extent funds are made available or as otherwise directed by an appropriations act. The Program and any benefits provided hereunder shall not be public assistance pursuant to Chapter 5 (§ 63.2-500 et seq.) of Title 63.2.

§ 2.2-214.10. Small Employer Managed Care Health Insurance Program Fund established.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Small Employer Managed Care Health Insurance Program Fund, hereafter referred to as "the Fund." The Fund shall be established on the books of the Comptroller and shall include any nongeneral funds appropriated by the General Assembly for the purposes of the Fund, any gifts, grants or bequests received from any private person or organization, and any funds that may be authorized by the federal government. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes of the Program as set out in this chapter, including costs to administer the Program. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued

by the Comptroller upon written request signed by the Secretary of Health and Human Resources.

B. The Auditor of Public Accounts or his legally authorized representative shall annually audit the accounts of the Fund in accordance with generally accepted auditing standards, and the cost of such audit services shall be borne by the Fund.

§ 2.2-214.11. Waiting list.

Should moneys in the Fund be insufficient to provide premium assistance for all eligible individuals enrolled in the Program, the Board shall establish and maintain a first-come, first-served waiting list. As funds become available, the Board shall approve and make such premium assistance based on the individual's place on the waiting list.

§ 2.2-2101. Prohibition against service by legislators on boards, commissions, and councils within the executive branch; exceptions.

Members of the General Assembly shall be ineligible to serve on boards, commissions, and councils within the executive branch of state government who are responsible for administering programs established by the General Assembly. Such prohibition shall not extend to boards, commissions, and councils engaged solely in policy studies or commemorative activities. If any law directs the appointment of any member of the General Assembly to a board, commission, or council in the executive branch of state government that is responsible for administering programs established by the General Assembly, such portion of such law shall be void, and the Governor shall appoint another person from the Commonwealth at large to fill such a position.

The provisions of this section shall not apply to members of the Board for Branch Pilots, who shall be appointed as provided for in § 54.1-901; to members of the Board of Trustees of the Southwest Virginia Higher Education Center, who shall be appointed as provided for in § 23-231.3; to members of the Board of Trustees of the Southern Virginia Higher Education Center, who shall be appointed as provided for in § 23-231.25; to members of the Board of Directors of the New College Institute who shall be appointed as provided for in § 23-231.31; to members of the Virginia Interagency Coordinating Council who shall be appointed as provided for in § 2.2-5204; to members of the Board of Veterans Services, who shall be appointed as provided for in § 2.2-2452; to members appointed to the Board of Trustees of the Roanoke Higher Education Authority pursuant to § 23-231.15; to members of the Commonwealth Competition Commission, who shall be appointed as provided for in § 2.2-2621; to members of the Virginia Geographic Information Network Advisory Board, who shall be appointed as provided for in § 2.2-2423; to members of the Advisory Commission on the Virginia Schools for the Deaf and the Blind, who shall be appointed as provided for in § 22.1-346.1; to members of the Substance Abuse Services Council, who shall be appointed as provided for in § 2.2-2696; to members of the Criminal Justice Services Board, who shall be appointed as provided in § 9.1-108; to members of the State Executive Council for Comprehensive Services for At-Risk Youth and Families, who shall be appointed as provided in § 2.2-2648; to members of the Virginia Workforce Council, who shall be appointed as provided for in § 2.2-2669; to members of the Commission on Civics Education, who shall be appointed as provided for in § 22.1-212.18; to members of the Volunteer Firefighters' and Rescue Squad Workers' Service Award Fund Board, who shall be appointed as provided for in § 51.1-1201; to members of the Secure Commonwealth Panel, who shall be appointed as provided for in § 2.2-306; to members of the Forensic Science Board, who shall be appointed as provided for in § 9.1-1109; ~~or~~ to members of the Virginia Commission on Immigration, who shall be appointed as provided in § 2.2-2530*; or to members of the Small Employer Managed Care Health Insurance Program Board, who shall be appointed as provided for in § 2.2-214.4.*

§ 2.2-2101. (Contingent effective date, see Editor's note) Prohibition against service by legislators on boards, commissions, and councils within the executive branch; exceptions.

Members of the General Assembly shall be ineligible to serve on boards, commissions, and councils within the executive branch of state government who are responsible for administering programs established by the General Assembly. Such prohibition shall not extend to boards, commissions, and councils engaged solely in policy studies or commemorative activities. If any law directs the appointment of any member of the General Assembly to a board, commission, or council in the executive branch of state government that is responsible for administering programs established by the General Assembly, such portion of such law shall be void, and the Governor shall appoint another person from the Commonwealth at large to fill such a position.

The provisions of this section shall not apply to members of the Board for Branch Pilots, who shall be appointed as provided for in § 54.1-901; to members of the Board of Trustees of the Southwest Virginia Higher Education Center, who shall be appointed as provided for in § 23-231.3; to members of the Board of Trustees of the Southern Virginia Higher Education Center, who shall be appointed as provided for in § 23-231.25; to members of the Board of Directors of the New College Institute who shall be appointed as provided for in § 23-231.31; to members of the Virginia Interagency Coordinating Council who shall be appointed as provided for in § 2.2-5204; to members of the Board of Veterans Services, who shall be appointed as provided for in § 2.2-2452; to members appointed to the Board of

Trustees of the Roanoke Higher Education Authority pursuant to § 23-231.15; to members of the Commonwealth Competition Commission, who shall be appointed as provided for in § 2.2-2621; to members of the Virginia Geographic Information Network Advisory Board, who shall be appointed as provided for in § 2.2-2423; to members of the Advisory Commission on the Virginia Schools for the Deaf and the Blind, who shall be appointed as provided for in § 22.1-346.1; to members of the Substance Abuse Services Council, who shall be appointed as provided for in § 2.2-2696; to members of the Criminal Justice Services Board, who shall be appointed as provided in § 9.1-108; to members of the State Executive Council for Comprehensive Services for At-Risk Youth and Families, who shall be appointed as provided in § 2.2-2648; to members of the Virginia Workforce Council, who shall be appointed as provided for in § 2.2-2669; to members of the Commission on Civics Education, who shall be appointed as provided for in § 22.1-212.18; to members of the Volunteer Firefighters' and Rescue Squad Workers' Service Award Fund Board, who shall be appointed as provided for in § 51.1-1201; to members of the Secure Commonwealth Panel, who shall be appointed as provided for in § 2.2-306; ~~or~~ to members of the Forensic Science Board, who shall be appointed as provided for in § 9.1-1109*; or to members of the Small Employer Managed Care Health Insurance Program Board, who shall be appointed as provided for in § 2.2-214.4*.

§ 38.2-3407.12. Patient optional point-of-service benefit.

A. As used in this section:

"Affiliate" shall have the meaning set forth in § 38.2-1322.

"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;

2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services plans which are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;

3. Any health maintenance organization licensed under this title which provides or arranges for the provision of one or more health care plans which are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;

4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans which are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and

5. Any other person licensed under this title which provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels which are subject to regulation as the business of insurance under this title.

"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service which is not paid by the carrier and for which the enrollee is responsible.

"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the enrollee to the provider towards the allowable charge as a condition of the receipt of specific health care items and services.

"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the enrollee as a condition to or consequence of the receipt of covered items or services.

"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.

"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.

"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.

"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in

the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C.

"Group specific administrative cost" means the direct administrative cost incurred by a carrier related to the offer of the point-of-service benefit to a particular group contract holder.

"Health care plan" shall have the meaning set forth in § 38.2-4300.

"Person" means any individual, corporation, trust, association, partnership, limited liability company, organization or other entity.

"Point-of-service benefit" means a health maintenance organization's delivery system or covered benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with the health maintenance organization, which permit an enrollee (and eligible dependents) to receive covered items and services outside of the provider panel, including optometrists and clinical psychologists, of the health maintenance organization under the terms and conditions of the group contract holder's group health benefit plan with the health maintenance organization or with another carrier arranged by or under contract with the health maintenance organization and which otherwise complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee (and eligible dependents) to receive the full range of covered items and services outside of a provider panel, including optometrists and clinical psychologists, and which are otherwise in compliance with applicable law and this section shall constitute a point-of-service benefit.

"Preferred provider organization plan" means a health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209.

"Provider" means any physician, hospital or other person, including optometrists and clinical psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health care items or services.

"Provider panel" means the participating providers or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health maintenance organization or other carrier.

B. To the maximum extent permitted by applicable law, every health care plan offered or proposed to be offered in this Commonwealth by a health maintenance organization licensed under this title to a group contract holder shall provide or include, or the health maintenance organization shall arrange for or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered in conjunction with the health maintenance organization's health care plan as an additional benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every health maintenance organization shall, at no additional cost to the group contract holder, make available or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance acceptable to the Commission which accurately and completely explains to the group contract holder and prospective enrollee the point-of-service benefit and permits each enrollee to make his or her election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the carrier in any reasonable manner.

C. To the extent permitted under applicable law, a health maintenance organization providing or arranging, or contracting with another carrier to provide, the point-of-service benefit under this section and a carrier providing the point-of-service benefit required under this section under arrangement or contract with a health maintenance organization:

1. May not impose, or permit to be imposed, a minimum enrollee participation level on the point-of-service benefit alone;

2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or § 38.2-4221 for items or services provided under the point-of-service benefit required under this section

solely on the basis of the license or certification of the provider to provide such items or services if the carrier otherwise covers the items or services provided and the provision of the items or services is within the provider's lawful scope of practice or authority; and

3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group prior to any enrollee electing to accept or reject the point-of-service benefit.

D. The premium imposed by a carrier with respect to enrollees who select the point-of-service benefit may be different from that imposed by the health maintenance organization with respect to enrollees who do not select the point-of-service benefit. Unless a group contract holder determines otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of any premium over the amount of the premium applicable to an enrollee who selects the coverage offered by the health maintenance organization without the point-of-service benefit and for any identifiable group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization; provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) thirty percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service benefit any condition or penalty designed to discourage the enrollee's selection or use of the

point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

H. Except as expressly otherwise permitted in this section or as otherwise required under applicable law, the scope of the health care items and services which are covered under the point-of-service benefit required under this section shall at least include the same health care items and services which would be covered if provided under the health maintenance organization's health care plan, including without limitation any items or services covered under a rider or endorsement to the applicable health care plan. Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing materials utilized with respect to such group health benefit plans that the scope of the benefits provided under the point-of-service option are at least as great as those provided through the HMO's health care plan for that group. Filings of point-of-service benefits submitted to the Commission shall be accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the point-of-service benefits includes at a minimum the same health care items and services as are provided under the HMO's group health care plan for that group.

I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the health maintenance organization's group health benefit plan which does not contain the point-of-service benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is offered in a manner which separates or otherwise differentiates it from the group health benefit plan which does not contain the point-of-service benefit.

J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit under this section with respect to any group health benefit plan offered to a group contract holder if the health maintenance organization determines in good faith that the group contract holder will be concurrently offering another group health benefit plan or a self-insured or self-funded health benefit plan which allows the enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization's panel.

K. This section shall apply only to group health benefit plans issued in the Commonwealth in the commercial group market by carriers regulated by this title and shall not apply to (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; ~~or~~ (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C*; or (vi) except as specifically noted in Article 2 (§ 38.2-5812 et seq.) of Chapter 58 of this title, Small Employer Managed Care Health Insurance Policies developed pursuant to such article.*

L. This section shall apply to group health benefit plans issued or renewed by carriers in this Commonwealth on or after July 1, 1998.

M. Nothing in this section shall operate to limit any rights or obligations arising under §§ 38.2-3407, 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312 or § 38.2-4312.1.

N. If any provision of this section or its application to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity shall not affect the other provisions or any other application of this section which shall be given effect without the invalid provision or application, and for this purpose the provisions of this section are declared severable.

CHAPTER 58.
MANAGED CARE HEALTH INSURANCE PLANS.
Article 1.
General Provisions.

§ 38.2-5801. General provisions.

A. No person shall operate an MCHIP in this Commonwealth unless the health carrier who directly or indirectly manages, owns, contracts with, or employs the providers for the plan is licensed in accordance with provisions in this title as an insurance company, a health maintenance organization, or a nonstock corporation organized in accordance with provisions in Chapter 42 (§ 38.2-4200 et seq.) or Chapter 45 (§ 38.2-4500 et seq.) of this title. Such health carrier shall be deemed responsible for the MCHIP and its compliance with this chapter and the provisions of Title 32.1 concerning quality assurance of MCHIPs. A health carrier may be responsible for more than one MCHIP; however, no MCHIP shall have more than one responsible health carrier.

B. Except as provided in subsection C, no person shall operate an MCHIP in this Commonwealth unless the health carrier responsible for the MCHIP holds an active or temporarily suspended certificate of quality assurance issued by the Department of Health.

C. ~~1.~~ A health maintenance organization applying for licensure under this title on or after July 1, 1998, ~~or whose application for such licensure is pending before the Commission on July 1, 1998,~~ shall request its initial certificate of quality assurance prior to licensing and a copy of its request shall be included with and made a part of the licensing application and material filed with the Commission pursuant to § 38.2-4301 and subsection B of § 38.2-5802. ~~Until July 1, 2000, (i) issuance~~ *Issuance* of a license under § 38.2-4302 shall be contingent upon receipt of notice from the State Health Commissioner that the health maintenance organization's description of its complaint system has been reviewed and approved by the State Health Commissioner ~~and (ii) upon~~. *Upon* issuance of the license *under § 38.2-4302,* such health maintenance organization shall be deemed in compliance with subsection B provided ~~no~~ *the State Health Commissioner has not revoked or failed to renew a* certificate of quality assurance *that* has been issued to the health maintenance organization ~~which has been revoked or not renewed by the State Health Commissioner. Effective July 1, 2000, issuance~~ . *Issuance* of a license under § 38.2-4302 shall be contingent upon the Department of Health's issuance of a certificate of quality assurance.

~~2. Until July 1, 2000, a health maintenance organization licensed under this title on and before July 1, 1998, shall be deemed in compliance with the provisions of this section if (i) a request for initial certification has been filed with the Department of Health on or before December 1, 1998, and is pending before the State Health Commissioner and (ii) no certificate has been issued to the health maintenance organization which has been revoked or not renewed by the State Health Commissioner.~~

~~3.~~ *D.* A health carrier, other than a health maintenance organization, responsible for an MCHIP pursuant to this chapter, shall request its initial certificate of quality assurance from the Department of Health on or before December 1, 1998, or becoming responsible for a MCHIP under this title. ~~Until July 1, 2000, such health carrier shall be deemed in compliance with the provisions of this section if (i) a request for initial certification is pending before the Department of Health and (ii) no certificate has been issued to the health carrier which has been revoked or not renewed by the State Health Commissioner.~~

~~D~~ *E.* The provisions of this chapter shall apply to all health carriers and all MCHIPs operating in this Commonwealth unless an exemption is recognized in accordance with § 38.2-3420; and, except as otherwise provided in this chapter, the provisions of this chapter shall be supplemental and in addition to those otherwise applicable under this title or Title 32.1.

§ 38.2-5802. Establishment of an MCHIP.

A. A health carrier, when applying for initial licensing under this title and with each request for renewal ~~that is to be effective on or after July 1, 1999~~, shall describe and categorize generally its *existing or planned* transactions and operations in ~~this~~ *the* Commonwealth, *as applicable,* that *may* influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services through its MCHIPs. Descriptions and categorization shall identify generally the arrangements that the health carrier has with providers with respect to the delivery of health care services. Descriptions of incentive arrangements shall include compensation methodology and incentives. The descriptions of incentive arrangements shall not include amounts of compensation and values of incentives. Renewal filings shall clearly identify new matter and material changes of information disclosed in the preceding filing.

B. A health carrier applying to the Department of Health for initial certification of quality assurance shall simultaneously file a copy of its request for certification with the Commission and shall include the list of providers required by § 38.2-5805. Such filings shall be assessed by the Department of Health.

C. In addition to items specified in subsection B, the initial filing under this chapter by a health carrier subject to subsection B of § 38.2-5801 shall include any forms of contracts, including any amendments thereto, made with health care providers enabling the health carrier to provide health care services through its MCHIPs to covered persons. Individual provider contracts and contracts with persons outside this Commonwealth shall not be filed with the Commission unless requested by the Commission or necessary to explain or fully disclose pursuant to subsection D operational changes that

are materially at variance with the information currently on file with the Commission. The health carrier shall maintain a complete file of all contracts made with health care providers which shall be subject to examination by the Commission. The contracts shall be retained in the file for a period of at least five years after their expiration. Notwithstanding the provisions of Chapter 37 (§ 2.2-3700 et seq.) of Title 2.2 of the Code of Virginia, such contracts shall be confidential and shall not be subject to discovery upon subpoena.

D. No MCHIP shall be operated in a manner that is materially at variance with the information submitted pursuant to this section. Any change in such information which would result in operational changes that are materially at variance with the information currently on file with the Commission shall be subject to the Commission's prior approval. If the Commission fails to act on a notice of material change within ~~thirty~~ *30* days of its filing, the proposed changes shall be deemed approved. A material change in the MCHIP's health care delivery system shall be deemed to result in operational changes that are materially at variance with the information on file with the Commission. The Commission may determine that other changes are material and may require disclosure to secure full and accurate knowledge of the affairs and condition of the health carrier.

E. A health carrier shall give notice to the State Health Commissioner of ~~the~~ *any* filings it makes with the Commission pursuant to this section.

~~F. The provisions of this section are applicable generally for all health carriers subject to licensure under this title. The provisions of this section shall be applied specifically as follows: (i) the provisions of subsection A are applicable for each health carrier requesting renewal of a license on or after July 1, 1998, and also for each health carrier applying for initial licensing on or after July 1, 1998; (ii) the provisions of subsection B shall be applied to any health carrier that files an application with the Department of Health for initial certification of quality assurance; (iii) the provisions of subsection C become applicable as soon as a health carrier makes a filing pursuant to this section; (iv) the filing requirements described in subsection D are applicable for all material filed with the Commission pursuant to this section, and shall be applied also when a health carrier proposes material changes to information of the type described in this section which previously had been filed with the Commission pursuant to provisions of Chapter 43 (§ 38.2-4300 et seq.) of this title; and (v) the provisions of subsection E are applicable whenever a health carrier makes a filing pursuant to this section.~~

Article 2.

Small Employer Managed Care Health Insurance Program.

§ 38.2-5812. Definitions.

For the purposes of this article:

"Board" means the Small Employer Managed Care Health Insurance Program Board established pursuant to § 2.2-214.4.

"Dependent" means the spouse of an eligible employee, subject to the applicable terms of the policy covering the eligible employee.

"Eligible employee" means an employee who satisfies the requirements set forth in § 2.2-214.8.

"Health insurance policy" means any individual or group accident and health insurance policy or subscription contract providing hospital, medical and surgical or major medical coverage in the Commonwealth. "Health insurance policy" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

"Insurer" means an insurance company or health services plan licensed in the Commonwealth to write accident and sickness insurance and operating as a managed care health insurance plan.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from an insurer, including fees and other contributions associated with a Small Employer Managed Care Health Insurance policy.

"Qualified small employer" has the same meaning ascribed to that term in § 2.2-214.3.

"Small Employer Managed Care Health Insurance policy" means a health insurance policy that is certified by the Board pursuant to § 2.2-214.7.

§ 38.2-5813. Issuance of policies.

Insurers offering a Small Employer Managed Care Health Insurance policy shall issue coverage to every eligible employee who elects to be covered under such policy, if the employee and employer have agreed to make the required premium payments.

§ 38.2-5814. Small Employer Managed Care Health Insurance policies.

Each Small Employer Managed Care Health Insurance policy shall satisfy all requirements established by the Board pursuant to § 2.2-214.5, as well as the requirements of this article, including the following:

1. The policy shall include cost containment and cost-sharing features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians and other health care providers, subject to the limitations set forth in § 38.2-3407; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; co-payment, co-insurance, deductible or other cost-sharing arrangement as those terms are defined in § 38.2-3407.12; or other managed care provisions.

2. No law requiring the coverage or 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 shall apply to the policy or riders thereof.

3. All insurers shall use a policy form approved by the Commission providing coverage that complies with regulations promulgated by the Board pursuant to § 2.2-214.5. An insurer shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. The Commission at any time may, after providing notice and an opportunity for a hearing to an insurer, disapprove the continued use by the insurer of a policy on the grounds that such policy does not meet the requirements of this article.

§ 38.2-5815. Market conduct.

In order to ensure the broadest availability of Small Employer Managed Care Health Insurance policies, the Commission shall set market conduct and other requirements for insurers and agents, including requirements relating to the following:

1. Documentation from each insurer that its Small Employer Managed Care Health Insurance policies have been certified by the Board;

2. Publication by the Commission of a list of all insurers who offer Small Employer Managed Care Health Insurance policies;

3. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers and their employees to information concerning this article; and

4. Periodic reports by insurers about Small Employer Managed Care Health Insurance policies issued, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health insurance polices in various categories marketed or issued. Insurers shall maintain data relating to the Small Employer Managed Care Health Insurance policies separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section.

§ 38.2-5816. Renewability.

If coverage pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

§ 38.2-5817. Availability.

A. If Small Employer Managed Care Health Insurance policies are offered under this article, they shall be offered and made available to all eligible employees of every qualified small employer, and their spouses, that apply for such coverage, and no coverage may be offered only to certain eligible

employees or their spouses, except as provided in § 2.2-214.9. No employees or their spouses may be excluded or charged additional premiums because of health status.

B. No coverage offered under this article shall exclude an eligible employee based solely on the nature of the employer's business.

C. Nothing in this article shall be construed to preclude an insurer from establishing employer contribution rules or group participation rules adopted by the Board in connection with Small Employer Managed Care Health Insurance policies.

§ 38.2-5818. Limitation on preexisting condition exclusion period.

An insurer offering a Small Employer Managed Care Health Insurance policy may impose a preexisting condition limitation only if, and to the extent, permitted under regulations promulgated by the Board.

§ 38.2-5819. Disclosure of information.

A. Any insurer issuing Small Employer Managed Care Health Insurance policies shall make a reasonable disclosure of the availability of information to a qualified small employer and its eligible employees, as part of its solicitation and sales materials, and upon request of such an employer, information concerning: (i) the provisions of such coverage concerning the insurer's right to change premium rates and the factors that may affect changes in premium rates; (ii) the provisions of such coverage relating to renewability of coverage; and (iii) the provisions of such coverage relating to any preexisting condition exclusion.

B. An insurer is not required under this article to disclose any information that is proprietary and trade secret information.

§ 38.2-5820. Eligibility.

A. An insurer offering Small Employer Managed Care Health Insurance policies may not establish rules for eligibility, including continued eligibility, of any individual under the terms of a policy based on any of the health status-related factors.

B. The provisions of this section shall not be construed:

1. To require the policy to provide particular benefits other than those provided under the terms of such plan or coverage; or

2. To prevent an insurer from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated insured individuals or coverage rules for eligibility to enroll under a policy that includes rules defining any applicable waiting periods for such enrollment.

C. An insurer offering Small Employer Managed Care Health Insurance policies may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the amount approved by the Board with respect to the policy.

2. That the Small Employer Managed Care Health Insurance Program Board established under this act shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

3. That the initial appointments to the Small Employer Managed Care Health Insurance Program Board established under this act shall be made by July 1, 2008, as follows: the Governor shall appoint two members for a term of one year each, two members for a term of two years each, and one member for a term of three years; the Speaker of the House shall appoint one member for a term of two years, one member for a term of three years, and one member for a term of four years; and the Senate Committee on Rules shall appoint one member for a term of three years and one member for a term of four years.

4. That the provisions of this act, other than the provisions amending and reenacting §§ 38.2-5801 and 38.2-5802 of the Code of Virginia, shall expire on July 1, 2011.