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HOUSE BILL NO. 368

Offered January 8, 2014
Prefiled January 3, 2014

A BILL to amend and reenact §§ 38.2-510, 38.2-4214, 38.2-4319, and 38.2-4509 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.19, relating to coverage for eye care provided under health benefit plans.

Patron—Head

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-510, 38.2-4214, 38.2-4319, and 38.2-4509 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.19 as follows:

§ 38.2-510. Unfair claim settlement practices.

A. No person shall commit or perform with such frequency as to indicate a general business practice any of the following:

1. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

2. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

3. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

4. Refusing arbitrarily and unreasonably to pay claims;

5. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

6. Not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

7. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

8. Attempting to settle claims for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

9. Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured;

10. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

11. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

12. Delaying the investigation or payment of claims by requiring an insured, a claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, when both contain substantially the same information;

13. Failing to promptly settle claims where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

14. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;

15. Failing to comply with § 38.2-3407.15, or to perform any provider contract provision required by that section;

16. Payment to an insurer or its representative by a repair facility, or acceptance by an insurer or its representative from a repair facility, directly or indirectly, of any kickback, rebate, commission, thing of value, or other consideration in connection with such person's appraisal service; ~~or~~

17. Making appraisals of the cost of repairing an automobile that has been damaged as a result of a collision unless such appraisal is based upon a personal inspection by a representative of the repair facility or the insurer who is making the appraisal*; or*

18. Failing to comply with § 38.2-3407.19.

B. No violation of this section shall of itself be deemed to create any cause of action in favor of any person other than the Commission; but nothing in this subsection shall impair the right of any person to

seek redress at law or equity for any conduct for which action may be brought.

C. 1. No insurer shall prepare or use an estimate of the cost of automobile repairs based on the use of an after market part, as defined herein, unless:

The insurer discloses to the claimant in writing either on the estimate or in a separate document attached to the estimate the following information:

"THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUAL IN LIKE KIND AND QUALITY IN TERMS OF FIT, QUALITY AND PERFORMANCE TO THE ORIGINAL MANUFACTURER PARTS THEY ARE REPLACING."

2. "After market part" as used in this section shall mean an automobile part which is not made by the original equipment manufacturer and which is a sheet metal or plastic part generally constituting the exterior of a motor vehicle, including inner and outer panels.

§ 38.2-3407.19. Access to eye care.

A. As used in this section, unless the context requires a different meaning:

"Carrier" means (i) an 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; (ii) a corporation providing individual or group accident and sickness subscription contracts; (iii) a health maintenance organization providing a health care plan for health care services; or (iv) a nonstock corporation operating an optometric or vision care services plan.

"Covered person" means an individual, whether a policyholder, subscriber, enrollee, covered dependent, or member, who is entitled to health care services or benefits provided, arranged for, paid for, or reimbursed pursuant to a health benefit plan, when such coverage is provided under a contract issued in the Commonwealth.

"Eye care" means those vision care services, optometric services, or health care services and materials related to the care of the eye and related structures that a carrier is obligated to pay for or provide to covered persons under the health benefit plan.

"Health benefit plan" means any (i) individual or group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; (ii) individual or group accident and sickness subscription contract; (iii) health care plan for health care services; or (iv) optometric or vision care services plan subject to regulation under Chapter 45 (§ 38.2-4500 et seq.).

"Health benefit plan provider panel" means those providers of eye care with which a carrier contracts to provide eye care to covered persons under the carrier's health benefit plan.

B. Notwithstanding any provision of § 38.2-3407 to the contrary, a carrier providing a health benefit plan that includes coverage for eye care shall:

1. Not set professional fees or reimbursement for the same eye care services as defined by established current procedural terminology codes in a manner that discriminates against an individual eye care provider or a class of eye care providers;

2. Not preclude a covered person who seeks eye care from obtaining such service directly from a provider on the health benefit plan provider panel who is licensed to provide eye care;

3. Not promote or recommend any class of eye care providers to the detriment of any other class of eye care providers for the same eye care service;

4. Ensure that all eye care providers on a health benefit plan provider panel are included on any publicly accessible list of participating eye care providers for the health benefit plan;

5. Allow each eye care provider on a health benefit plan provider panel, without discrimination between classes of eye care providers, to furnish covered eye care services to covered persons to the extent permitted by such provider's licensure;

6. Not require any eye care provider to hold hospital privileges or impose any other condition or restriction for initial admittance to a health benefit plan provider panel not necessary for the delivery of eye care upon such providers which would have the effect of excluding an individual eye care provider or class of eye care providers from participation on the health benefit plan provider panel; and

7. Include opticians, optometrists, and ophthalmologists on the health benefit plan provider panel in a manner that ensures covered persons timely access and geographic access to eye care.

C. Nothing in this section shall preclude a covered person from receiving eye care or other covered services from a physician in accordance with the terms of the health benefit plan.

D. Nothing in this section requires a health benefit plan to include coverage for eye care.

E. Any person who suffers loss as the result of a carrier's violation of this section shall be entitled to initiate an action for injunctive relief against such carrier and, upon prevailing, in addition to any injunctive relief that may be granted, shall recover from the carrier damages of not more than $100. In addition to any damages awarded, such person also may be awarded reasonable attorney fees and court costs.

F. No carrier shall terminate or fail to renew the contractual relationship with an eye care provider, or otherwise penalize any eye care provider, for invoking any of the eye care provider's rights under this section.

G. This section shall apply only to carriers subject to regulation under this title.

H. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

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

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through ~~38.2-3407.18~~ *38.2-3407.19*, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

§ 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, 38.2-316.1, 38.2-322, 38.2-326, 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.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, 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, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through ~~38.2-3407.18~~ *38.2-3407.19*, 38.2-3411, 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 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 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, 38.2-3540.2, 38.2-3541.1, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) 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.) 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.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, 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, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, *38.2-3407.19*, 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, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) 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.) 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.

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.

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.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.1, 38.2-3407.4, 38.2-3407.10, 38.2-3407.13, 38.2-3407.14, 38.2-3407.15, 38.2-3407.17, *38.2-3407.19*, 38.2-3415, 38.2-3541, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall apply to the operation of a plan.

B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

C. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not apply to either an optometric or dental services plan.

D. The provisions of § 38.2-3407.1 shall apply to claim payments made on or after January 1, 2014. No optometric or dental services plan shall be required to pay interest computed under § 38.2-3407.1 if the total interest is less than $5.