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SENATE BILL NO. 860

Offered January 17, 2018

A BILL to amend and reenact § 38.2-3407.10 of the Code of Virginia, relating to health care provider panels; vertically integrated carriers; reimbursements to public hospitals.

Patrons—Lucas and Locke

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

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

§ 38.2-3407.10. Health care provider panels.

A. As used in this section:

"Carrier" means:

1. Any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;

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

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

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

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

"Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person or entity, whether (i) through the ownership of voting securities; (ii) by contract, other than a commercial contract for goods or nonmanagement services; (iii) by contract for goods or nonmanagement services where the volume of activity results in a reliance relationship; (iv) by common management; or (v) by any other means. Control shall be presumed to exist if a reporting entity and its affiliates directly or indirectly own, control, hold with the power to vote, or hold proxies representing 10 percent or more of the voting interests of the entity.

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

"Owns," "is owned," and "ownership" mean ownership of an equity interest, or the equivalent thereof, of 10 percent or more.

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

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

"Public hospital" means an acute care hospital facility operating in the Commonwealth that is owned or operated by a hospital authority established pursuant to Chapter 53 (§ 15.2-5300 et seq.) of Title 15.2 or an act of assembly, a state or municipal government agency, or other political subdivision of the Commonwealth.

"Vertically integrated carrier" means a carrier that owns or controls, is owned or controlled by, or is under common ownership or control with, an individual, partnership, committee, association, corporation, or any other organization or group of persons that, either directly or through one or more affiliates or subsidiaries, owns, operates, or manages one or more acute care hospital facilities operating in the Commonwealth. "Vertically integrated carrier" shall not include an entity that is owned jointly by one entity that owns, controls, or operates an acute care hospital and one entity that is licensed to sell insurance or administer benefits within the Commonwealth so long as the two entities do not share the same ultimate controlling entity.

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

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

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

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

1. Notifying an enrollee of:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G. 1. A carrier shall provide to a purchaser upon enrollment and make available to existing enrollees at least once a year a list of members in its provider panel, which list shall also indicate those providers who are not currently accepting new patients. Such list 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. The information provided under subdivision 1 shall be updated at least once a year if in paper form, and monthly if in electronic form.

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

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

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

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

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

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

N. No contract between a provider and a carrier shall include provisions that require a health care

provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions.

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

P. A carrier that rents or leases its provider panel to unaffiliated carriers shall make available, upon request, to its providers a list of unaffiliated carriers that rent or lease its provider panel. Such list if available in electronic format shall be updated monthly. The provider shall be given the means to request and receive a printed copy of such list.

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

R. *Each vertically integrated carrier shall offer participation in each provider panel or network established for each of the vertically integrated carrier's policies, products, and plans to every public hospital, as follows:*

1. Such participation shall:

a. Be without any adverse tiering or other financial incentives that may discourage enrollees from utilizing the services of the public hospital; and

b. Include all services offered by the public hospital and any other entity owned, operated, or controlled by a public hospital, in whole or in part.

2. Any contract by which a public hospital participates in a vertically integrated carrier's provider panel or network shall obligate the vertically integrated carrier to reimburse the public hospital and any other entity owned, operated, or controlled by a public hospital for a covered health care service at a rate that is not less than the fair and nondiscriminatory rate. As used in this subdivision:

"Fair and nondiscriminatory rate," with respect to a covered health care service, means a rate that is not less than the product obtained by multiplying (i) the median of all percentage premiums by (ii) the Medicare fee-for-service rates for the health care service.

"Percentage premium" means the percentage by which the rate that the vertically integrated carrier has agreed to pay each of the acute care hospitals that it owns or with which it shares ownership or control for a health care service exceeds the Medicare fee-for-service rates for the health care service. The percentage premium shall be expressed as a percentage of the Medicare fee-for-service rate.

3. Any contract by which a public hospital participates in a vertically integrated carrier's provider panel or network shall:

a. Require the vertically integrated carrier, within 14 days following receipt of a written request from a public hospital, to disclose the amount calculated by the vertically integrated carrier to be the fair and nondiscriminatory rate for a covered health care service;

b. Require the vertically integrated carrier, within 30 days following receipt of a written notice from the public hospital disputing such calculation of the fair and nondiscriminatory rate for a covered health care service, to retain at its sole expense an independent, nationally recognized accounting or actuarial consulting firm, without conflicts of interest, to audit and verify the calculation of the fair and nondiscriminatory rate for the health care service. The consulting firm shall share its findings with the public hospital and shall retain its final report and supporting working papers and files for a period of five years; and

c. Provide that if the vertically integrated carrier fails to reimburse the public hospital for a covered

health care service at a fair and nondiscriminatory rate, the public hospital shall be authorized to bring a civil action in an appropriate court to recover from the vertically integrated carrier the difference between the fair and nondiscriminatory rate for the health care service and any amount previously paid by the carrier therefor, with prejudgment interest, or for injunctive or declaratory relief. If the public hospital prevails in such action, it shall be entitled to recover its reasonable attorney fees and costs.

S. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on or after July 1, 1996. However, the 90-day period referred to in subdivisions C 1 b and C 2 ~~of this section~~, the requirements set forth in subdivisions F 2 and F 3, and the requirements set forth in subsections L, M, and N shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1999~~,~~*;* the requirements set forth in subsection O shall apply to contracts between carriers and providers that are entered into, reissued, extended or renewed on or after July 1, 2001~~, and~~*;* the requirements set forth in subsection P shall be effective on and after January 1, 2007*; and the requirements set forth in subsection R shall apply to contracts between carriers and providers that are entered into, reissued, extended, or renewed on or after July 1, 2018.*