VIRGINIA ACTS OF ASSEMBLY -- 1994 SESSION

CHAPTER 213

An Act to amend and reenact §§ 32.1-325.2, 38.2-3411.2, 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 38.2-508.3 and 38.2-3405.1 and by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.2, relating to payments made for medical assistance.

[H 1057]

Approved April 2, 1994

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-325.2, 38.2-3411.2, 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.2-508.3 and 38.2-3405.1 and by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.2 as follows:

§ 32.1-325.2. Department is payor of last resort.

A. ~~Medical insurance carriers,~~ *Insurers, including group health plans as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, health services plans, service benefit plans and health maintenance organizations,* are prohibited from including any clause in health care ~~insurance~~ contracts which would exclude ~~payment for health care to individuals~~ *enrolling an individual or in making any payment for benefits to the individual or on the individual's behalf for health care when the individual is* eligible for medical assistance.

B. The Department of Medical Assistance Services will be the payor of last resort to any ~~health care insurance carrier~~ *insurer, including a group health plan as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, a health services plan, a service benefit plan and a health maintenance organization,* which contracts to pay health care costs for persons eligible for medical assistance in the Commonwealth.

C. To the extent the Department of Medical Assistance Services has made payment for medical services where a third party has a legal obligation to make payment for such services, the Commonwealth shall automatically acquire all rights to such payment from the third party.

D. The term "insurer" as used herein shall be deemed to include without limitation "insurance carriers."

§ 38.2-508.3. Consideration of Medicaid eligibility prohibited.

A. No person shall, in determining the eligibility of an individual for coverage under an individual or group accident and sickness policy, health services plan or health maintenance organization contract, consider the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

B. No person shall, in determining benefits payable to, or on behalf of an individual covered under an individual or group accident and sickness policy, health services plan or health maintenance organization contract, take into account the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

§ 38.2-3405.1. Commonwealth's right to certain accident and sickness benefits.

A. The Department of Medical Assistance Services shall be entitled to direct reimbursement under any accident and sickness insurance policy, health services plan, or health maintenance organization contract for covered services or items to the extent that payment has been made by the Department of Medical Assistance Services on behalf of an individual covered under such policy, plan, or contract for such services or items.

B. No insurer, health services plan, or health maintenance organization shall impose upon the Department of Medical Assistance Services or any state agency, which has been assigned or has otherwise acquired the rights of an individual eligible for medical assistance ("Medicaid") and covered for health benefits by the insurance policy, health services plan, or health maintenance organization contract, any requirements that are different from requirements applicable to an agent or assignee of any other individual so covered.

§ 38.2-3407.2. Coverage for medical child support.

A. No insurer, health services plan, or health maintenance organization shall refuse to enroll a child under a parent's coverage because (i) the child was born out of wedlock; (ii) the child is not claimed as a dependent on the parent's federal income tax return; or (iii) the child does not reside with the parent or in the insurer's, health services plan's, or health maintenance organization's service area.

B. Upon receipt of proof that a parent eligible for family coverage under an accident and sickness policy, health services plan, or health maintenance organization contract has been required by a court or administrative order to provide health coverage for a child, the insurer, health services plan, or health maintenance organization shall:

1. Permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage, without regard to any enrollment season restrictions;

2. If such parent is enrolled but fails to make application to obtain coverage for such child, enroll such child upon application by the child's other parent or by the Department of Social Services; and

3. Not disenroll or otherwise eliminate coverage of such child unless the insurer, health services plan, or health maintenance organization is provided satisfactory written evidence that:

a. Such court or administrative order is no longer in effect;

b. Such child is or will be enrolled in comparable health coverage through another insurer, health services plan, or health maintenance organization which will take effect not later than the effective date of termination of the child's coverage under the policy or contract issued by the insurer, health services plan, or health maintenance organization; or

c. Family health coverage has been eliminated under the insurance policy, health services plan, or health maintenance organization contract.

C. Any insurer, health services plan, or health maintenance organization providing coverage to the child of a noncustodial parent shall (i) provide to the custodial parent, upon request, any information that is necessary to obtain benefits for such child under such coverage; (ii) permit the custodial parent, or the provider of health services if approved by the custodial parent, to submit claims for services without the approval of the noncustodial parent; and (iii) make payment on claims submitted pursuant to clause (ii) directly to such custodial parent, provider, or the Department of Medical Assistance Services.

§ 38.2-3411.2. Coverage of adopted children required.

A. Notwithstanding the provisions of § 38.2-3419, each 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, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization providing a health care plan for health care services that offers coverage for a family member of the insured, subscriber, or plan enrollee, shall, as to the family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to adopted children of the insured, subscriber, or plan enrollee.

B. The coverage of such policy, subscription, or plan, applicable to family members of the insured, subscriber or enrollee, shall apply in the same manner and to the same but no greater extent to adopted children of the insured, subscriber or enrollee.

C. An adopted child shall be eligible for the coverage required by this section from the date of adoptive or parental placement with an insured, subscriber or plan enrollee for the purpose of adoption; and, in addition as to a child whose adoptive or parental placement has occurred within thirty-one days of birth, such child shall be considered a newborn child of the insured, subscriber or plan enrollee as of the date of adoptive or parental placement. Once coverage is in effect, it shall continue according to the terms of the policy, subscription contract, or plan, unless the said placement is disrupted prior to final decree of adoption, and the child is removed from placement with the insured, subscriber or plan enrollee.

D. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or subscription contract may require notification of the placement of an adoptive child and payment of the required premium or fees shall be furnished to the insurer issuing the policy or corporation issuing the subscription contract within thirty-one days after the date of parental or adoptive placement in order to have the coverage continue beyond the thirty-one-day period.

E. No insurer, health services plan or health maintenance organization shall restrict coverage for any dependent child adopted or placed for adoption solely because of a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the plan.

§ 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, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 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, 38.2-1317 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,* 38.2-3407.1, *38.2-3407.2,* 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 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, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600

through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1310, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, *38.2-3405.1*, *38.2-3407.2*, 38.2-3411.2, 38.2-3418.1, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. 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.