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HOUSE BILL NO. 1393

Offered January 22, 1996

A BILL to amend and reenact §§ 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 38.2-3407.10, relating to accident and sickness insurance; health care provider panels.

Patrons—Plum, Abbitt, Armstrong, Cranwell, Davies, Hargrove, Harris, Hull, Johnson, McEachin, Morgan and Thomas; Senators: Edwards, Houck, Lambert, Lucas, Marsh, Saslaw, Trumbo and Williams

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That §§ 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 38.2-3407.10 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 a carrier.

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

"Out-of-pocket limit" means the total amount of potential deductible, copayment, coinsurance or any other cost-sharing mechanism required to be paid by or on behalf of an enrollee of a carrier for one year.

"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.

B. One or more carriers may offer a health benefit plan that limits the choice of an enrollee to members of a provider panel for the provision of health care services eligible for payment under the plan, provided that the plan also provides an option for an enrollee to receive health care services outside the provider panel pursuant to subsection M.

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

1. Notice of the development of each provider panel shall be filed with the Bureau of Insurance so as to provide reasonable notice to the maximum number of providers that reasonably can be anticipated to submit applications for inclusion in the provider panel. Notice shall also be provided to statewide health care provider organizations. In addition, carriers shall provide a provider application and the relevant terms and conditions to a provider upon request.

2. All provider applications or proposals submitted in accordance with the format and procedure prescribed by the carrier shall be given reasonable consideration.

3. Providers who submit a complete provider application shall be notified, in writing, of the carrier's decision regarding acceptance or denial. For providers not accepted into the provider panel, such notice shall include the reason or reasons for the carrier's decision.

4. An internal review process shall be established whereby, upon written request, a provider who is not accepted into the provider panel may request a review of his application. Such request for review shall be made by a provider within thirty days of receipt of the carrier's decision. The review shall be conducted on behalf of the carrier by individuals (i) who did not participate in making the decision being reviewed and (ii) who are at higher management levels than the individuals who rendered such decision. The carrier shall respond in writing to the provider within thirty days of receipt of a

provider's written request for review, advising the provider of the results thereof.

5. A carrier shall not, without cause, (i) terminate the contract of any provider or (ii) suspend, revoke or limit the participating status of any provider. Prior to the effective date of the termination, suspension, revocation or limitation, the carrier shall disclose to the provider, in writing, all reasons for the action. Whenever a contract is terminated for quality of care reasons, the carrier shall identify those reasons with specificity.

D. 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 ninety days from the date of the primary care provider's notice of termination from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency or loss of licensure status by the provider.

2. Notifying a provider at least ninety days prior to the date of the termination of the provider for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status by the provider.

3. Notifying primary care providers in the carrier's provider panel of the termination of a specialty referral services provider.

4. Notifying a new enrollee who, at the time of his enrollment, is receiving health care services from a provider who is not a member of the carrier's provider panel of the procedure and opportunity for his treating provider to become a member of the carrier's provider panel so that the new enrollee is able to provide such information to the treating provider.

5. 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. The percentage of the premium charged which is spent on the direct provision of health care services;

b. The details of any and all financial incentives which limit the amount or type of health care services which can be provided; and

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

E. A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

1. Gender, race, age, religion, national origin, or a protected category under the Americans With Disabilities Act.

2. The type or number of appeals filed by the provider.

3. The type or the number of complaints or grievances the provider filed or requested for advocating the interest of his patient or patients in a utilization review process, unless the provider engages in a pattern of filing appeals that are without merit.

F. 1. For a period of at least ninety days from the date of the notice of a provider's termination from the carrier's provider panel for reasons unrelated to fraud, patient abuse, legal incompetency, or loss of licensure status by the provider, the provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees who:

a. Were receiving health care services from the provider prior to the notice of termination; and

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

2. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with panel providers.

G. 1. A carrier shall provide to a new enrollee prior to enrollment and to existing enrollees at least once a year:

a. A list of members in its provider panel; and

b. Information on providers who are no longer accepting new patients.

2. The information provided under subdivision 1 shall be updated at least once a year.

H. A carrier that reimburses a provider on an aggregate fixed sum basis or on a per capita basis may not utilize withholds to reimburse the provider in an amount less than the sum or rate negotiated in the carrier's provider contract with the provider.

I. No contract between a carrier and a provider may require that the provider indemnify the managed care company, other organizations or carrier for any expenses and liabilities including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges incurred in connection with any claim or action brought against a managed care company, other organization or carrier on the basis of its determination of medical necessity or appropriateness of health care services if the information provided by said provider used in making the determination was accurate and appropriate at the time it was made.

J. 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.

K. No contract between a carrier and a provider shall require a provider to pay any fee for participation in a provider panel.

L. 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.

M. 1. Any carrier offering a plan formed pursuant to subsection B shall provide a point-of-service option for an enrollee to receive health care services from a provider who is not a member of the provider panel.

2. No charges to the enrollee of the point-of-service option, including but not limited to any higher premiums or out-of-pocket limits, may exceed the true actuarial cost, including administrative costs, to the insurer. A point-of-service option shall, however, provide for the same payment for a covered commodity or equipment as is provided in the same plan without a point-of-service option.

3. A carrier shall inform an enrollee of the point-of- service option of his right to receive health care services from a provider who is not a member of the panel, the terms of such coverage and the procedures necessary to exercise such option.

4. A carrier may not refuse to reimburse a provider providing services under this subsection solely on the basis of the license, certification or authorization of the provider to provide services if the carrier otherwise covers the service provided and such service is within the provider's lawful scope of practice.

N. The Commission may issue regulations to establish minimum standards to implement 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, 38.2-210 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 through 38.2-3407.6, 38.2-3407.9, *38.2-3407.10*, 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, 38.2-3514.1, 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 (§ 38.2-5300 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, 38.2-200, 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 38.2-1309, 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 through 38.2-3407.6, 38.2-3407.9, *38.2-3407.10*, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 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 et seq.) 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.

§ 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, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 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, 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, *38.2-3407.10*, 38.2-3415, 38.2-3541, and 38.2-3600 through 38.2-3603 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.