VIRGINIA ACTS OF ASSEMBLY -- 1997 SESSION

CHAPTER 297

An Act to amend and reenact § 38.2-4312 of the Code of Virginia, relating to health maintenance organizations; continuing care facilities; prohibited practices.

[H 2870]

Approved March 12, 1997

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4312 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-4312. Prohibited practices.

A. No health maintenance organization or its representative may cause or knowingly permit the use of (i) advertising that is untrue or misleading, (ii) solicitation that is untrue or misleading, or (iii) any form of evidence of coverage that is deceptive. For the purposes of this chapter:

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee or person considering enrollment in a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if the statement or item of information may be understood by a reasonable person who has no special knowledge of health care coverage as indicating (i) a benefit or advantage if that benefit or advantage does not in fact exist or (ii) the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee or person considering enrollment in a health care plan if the absence of that exclusion, limitation, or disadvantage does not in fact exist; consideration shall be given to the total context in which the statement is made or the item of information is communicated; and

3. An evidence of coverage shall be deemed to be deceptive if it causes a reasonable person who has no special knowledge of health care plans to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage; consideration shall be given to the evidence of coverage taken as a whole and to the typography, format, and language.

B. The provisions of Chapter 5 *(§ 38.2-500 et seq.)* of this title shall apply to health maintenance organizations, health care plans, and evidences of coverage except to the extent that the Commission determines that the nature of health maintenance organizations, health care plans, and evidences of coverage render any of the provisions clearly inappropriate.

C. No health maintenance organization may cancel or refuse to renew the coverage of an enrollee on the basis of the status of the enrollee's health.

D. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature (i) any of the words "insurance," "casualty," "surety," "mutual," or (ii) any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or fidelity and surety insurer doing business in this Commonwealth.

E. No health maintenance organization shall discriminate on the basis of race, creed, color, sex or religion in the selection of health care providers for participation in the organization.

F. No health maintenance organization shall unreasonably discriminate against physicians as a class or any class of providers listed in § 38.2-4221 or pharmacists when contracting for specialty or referral practitioners or providers, provided the plan covers services which the members of such classes are licensed to render. Nothing contained in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the numbers of providers necessary to render the services offered by the health maintenance organization.

G. The following provisions shall apply whenever a health maintenance organization provides an enrollee who is also a resident of a continuing care facility with coverage for Medicare benefits and the enrollee's primary care physician determines that it is medically necessary for the enrollee to be referred to a skilled nursing unit:

1. The health maintenance organization shall not require that the enrollee relocate to a skilled nursing unit outside the continuing care facility if (i) the continuing care facility's skilled nursing unit is certified as a Medicare skilled nursing facility and (ii) the continuing care facility agrees, as to such skilled nursing unit, to become a contracting provider in accordance with the health maintenance organization's standard terms and conditions for its participating providers.

2. A continuing care facility that satisfies clauses (i) and (ii) of subdivision 1, shall not be obligated to accept as a skilled nursing unit patient any one other than a resident of the continuing care facility; and neither the health maintenance organization nor the continuing care facility shall be allowed to include the skilled nursing unit or facilities on the list required by § 38.2-4311 or to advertise in any

other way that the facility's skilled nursing unit is a participating provider with respect to coverage offered by the health maintenance organization for Medicare benefits or skilled nursing unit facilities for other than the continuing care facility's residents.

3. As used in this subsection, "Medicare benefits" means medical and health products, benefits and services offered in accordance with Title XVIII of the United States Social Security Act and "continuing care facility" means a continuing care retirement community regulated pursuant to Chapter 49 (§ 38.2-4900 et seq.) of this title.