963439352

HOUSE BILL NO. 1015

Offered January 22, 1996

A BILL to amend and reenact §§ 38.2-3407, 38.2-4209 and 38.2-4311 of the Code of Virginia, relating to accident and sickness insurance; terms and conditions of contracts with providers.

Patron—Melvin

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3407, 38.2-4209 and 38.2-4311 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3407. Health benefit programs.

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. *Insurers shall make such terms and conditions available to the public upon written request. However, insurers shall not be required to disclose terms and conditions which contain proprietary information.* No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

C. Mandated types of providers set forth in § 38.2-3408, and types of providers whose services are required to be made available and that have been specifically contracted for by the holder of any such policy or contract shall, to the extent required by § 38.2-3408, have the same opportunity to qualify for payment as a preferred provider as do doctors of medicine.

D. Preferred provider policies or contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

E. For the purposes of this section, "preferred provider policies or contracts" are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.

§ 38.2-4209. Preferred provider subscription contracts.

A. As used in this section, a "preferred provider subscription contract" is a contract that specifies how services are to be covered when rendered by providers participating in a plan, by nonparticipating providers, and by preferred providers.

B. Notwithstanding the provisions of §§ 38.2-4218 and 38.2-4221, any nonstock corporation may, as a feature of its plan, offer preferred provider subscription contracts pursuant to the requirements of this section that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or other type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. *Nonstock corporations shall make such terms and conditions available to the public upon written request. However, nonstock corporations shall not be required to disclose terms and conditions which contain proprietary information.* No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded. Differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or price differences among providers in different geographical areas shall not be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

D. Mandated types of providers listed in § 38.2-4221 and types of providers whose services are required to be made available and which have been specifically contracted for by the holder of any subscription contract shall, to the extent required by § 38.2-4221, have the same opportunity as do doctors of medicine to qualify for payment as preferred providers.

E. Preferred provider subscription contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

§ 38.2-4311. Provider contracts.

A. Each health maintenance organization shall file with the Commission a list of the current providers who have executed a contract directly with the health maintenance organization or indirectly through an intermediary organization. The list shall include the names and localities of all providers who have signed a contract with the health maintenance organization or an intermediary organization. The list shall be updated by the health maintenance organization as of each calendar quarter ending December 31, March 31, June 30 and September 30, and shall be filed on or before March 1, May 15, August 15 and November 15 respectively each year.

B. Every contract with a provider of health care services enabling a health maintenance organization to provide health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization. An agreement to provide health care services between a provider and a health maintenance organization shall require that if the provider terminates the agreement, the provider shall give the health maintenance organization at least sixty-days' advance notice of termination. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

C. If there is an intermediary organization enabling a health maintenance organization to provide health care services by means of the intermediary organization's own contracts with health care providers, the contracts between the intermediary organization and its providers shall be in writing. The contracts shall set forth that in the event either the health maintenance organization or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health maintenance organization, the subscriber or enrollee shall not be liable to the provider for any sums owed by either the intermediary organization or the health maintenance organization. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization or the intermediary organization. An agreement to provide health care services between an intermediary organization and a health maintenance organization shall require that if the intermediary organization terminates the agreement, the intermediary organization shall give the health maintenance organization at least sixty-days' advance notice of termination. An agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty-days' advance notice of termination.

D. Each health maintenance organization and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review for a period of five years after the expiration of any such contract.

E. The terms and conditions of every contract with a provider of health care services enabling a health maintenance organization to provide health care services shall be made available to the public upon written request. However, a health maintenance organization shall not be required to disclose terms and conditions which contain proprietary information.