993334845

SENATE BILL NO. 895

Offered January 14, 1999

A BILL to amend and reenact §§ 32.1-122.10:01, 38.2-415, and 38.2-1437.1 of the Code of Virginia, relating to insurance; technical amendments.

Patron—Holland

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-122.10:01, 38.2-415, and 38.2-1437.1 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-122.10:01. Review of health maintenance organizations.

A. The State Health Commissioner (the "Commissioner") shall examine the quality of health care services of any health maintenance organization ("HMO") licensed in Virginia pursuant to §§ 38.2-4301 and 38.2-4302 and, at the Commissioner's discretion, the providers with whom the organization has contracts, agreements, or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth. The Commissioner shall consult with HMOs and providers in carrying out his duties under this section.

B. For the purposes of examinations, the Commissioner may review records, take affidavits, and interview the officers and agents of the HMO and the principals of the providers concerning their business.

C. The Commissioner shall collect annually, for distribution to consumers who make health benefit enrollment decisions, data consistent with the latest version of the health employer data information set (HEDIS), as required by the National Committee for Quality Assurance, from health maintenance organizations to evaluate comparatively on a plan level the quality of care delivered by HMOs as follows: information concerning the quality and performance of medical services provided by the health maintenance organization relating to the (i) effectiveness of care, (ii) access and availability of care, (iii) member satisfaction with the experience of care, (iv) health plan stability, (v) use of services, (vi) cost of care, (vii) informed health care choices, and (viii) health plan descriptive information. The Board may promulgate regulations to assess upon HMOs a fee to cover the costs of distributing or disseminating to consumers information or reports pursuant to this subsection.

The Commissioner may, at his discretion, contract with the nonprofit organization pursuant to § 32.1-276.4 to carry out the provisions of this subsection.

D. The expenses of examinations by or for the Commissioner under this section shall be assessed against the organization being examined and remitted to the Commissioner. Further, the Commissioner may report any noncompliance with the provisions of this section to the State Corporation Commission.

E. In making his examination, the Commissioner may consider the report of an examination of a foreign HMO certified by the insurance supervisory official, a similar regulatory agency, an independent recognized accrediting organization, or the state health commissioner of another state.

F. The Commissioner also shall: (i) consult with HMOs in the establishment of their complaint systems as provided in *subdivision C 1 of § 38.2-5801 and* § 38.2-5804; (ii) review and analyze HMOs' complaint reports which are required in subsection ~~B~~ *C* of § 38.2-5804; (iii) prepare, and make available to consumers, an annual summary of all complaints filed by enrollees of HMOs; and (iv) assist the State Corporation Commission in examining such complaint systems, as provided in subsection ~~C~~ *B* of § 38.2-5804. The Commissioner, in making this report, may contract with the nonprofit organization pursuant to § 32.1-276.4. The Commissioner may charge consumers requesting copies of the summary a fee to cover actual costs of copying or publishing the document.

G. The Commissioner shall coordinate the activities undertaken pursuant to this section with the State Corporation Commission to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

H. This section shall expire upon the earlier of (i) promulgation and final adoption of regulations governing certification of quality assurance for managed care health insurance plan licensees pursuant to Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 of this title or (ii) July 1, 2000.

§ 38.2-415. (Effective January 1, 1999 through January 1, 2003) Assessment to fund program to reduce losses from insurance fraud.

A. Each licensed insurer doing business in the Commonwealth by writing any type of insurance as defined in §§ 38.2-110 through 38.2-122.1 and 38.2-124 through 38.2-132 shall pay, in addition to any other assessments provided in this title, an assessment in an amount equal to 0.05 of one percent of the

direct gross premium income ~~collected~~ during the preceding calendar year. The assessment shall be apportioned and assessed and paid as prescribed by § 38.2-403. The Commission shall be reimbursed from the fund for all necessary expenses for the administration of this section.

B. The assessments made by the Commission under subsection A and paid into the state treasury shall be deposited to a special fund designated "Virginia State Police, Insurance Fraud," and out of such special fund and the unexpended balance thereof shall be appropriated the sums necessary for accomplishing the powers and duties assigned to the Virginia State Police under Chapter 9 (§ 52-36 et seq.) of Title 52. All interest earned from the deposit of moneys accumulated in the Fund shall be deposited in the Fund for the same use.

C. The moneys deposited in the Fund shall not be considered general revenue of the Commonwealth but shall be used only to (i) effectuate the purposes enumerated in Chapter 9 (§ 52-36 et seq.) of Title 52 and (ii) reimburse the Commission for its necessary expenses for the administration of this section. The Fund shall be subject to audit by the Auditor of Public Accounts.

D. In the event that the Insurance Fraud Investigation Unit is dissolved by operation of law or otherwise, any balance remaining in the Fund, after deducting administrative costs associated with the dissolution, shall be returned to insurers in proportion to their financial contributions to the Fund in the preceding calendar year.

§ 38.2-1437.1. Mortgage pass-through securities.

A domestic insurer may invest in mortgage pass-through securities backed by a pool of mortgages of the kind, class and investment quality as those eligible for investment under §§ 38.2-1434 through 38.2-1437, under the following conditions:

1. The servicer of the pool of mortgages shall be a business entity created under the laws of the United States or any state;

2. The pool of mortgages is assigned to a business entity, other than a sole proprietorship, having a ~~new~~ *net* worth of at least five million dollars, as trustee for the benefit of the holders of the securities;

3. A domestic insurer shall not invest under this section more than two percent of its admitted assets in securities backed by any single mortgage pass-through pool;

4. All mortgage pass-through securities acquired by a domestic insurer under this section shall provide for flow-through of both principal and interest payments payable on the underlying mortgage loan assets; mortgage pass-through securities promising principal-only, interest-only or residual interests-only in the underlying mortgage assets shall not be acquired; and

5. The securities on the date of investment shall be high grade obligations.