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HOUSE BILL NO. 1208

Offered January 24, 2000

A BILL to amend and reenact §§ 32.1-137.1 and 38.2-5800 of the Code of Virginia, relating to managed care health insurance plans.

Patron—Cantor

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.1 and 38.2-5800 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-137.1. Definitions.

As used in this and the following article, unless the context indicates otherwise:

"Agent" or "insurance agent," when used without qualification, means an individual, partnership, limited liability company, or corporation that solicits, negotiates, procures or effects contracts of insurance or annuity in this Commonwealth.

"Bureau of Insurance" means the State Corporation Commission acting pursuant to Title 38.2.

"Complaint" means any written communication from a covered person primarily expressing a grievance.

"Covered person" means an individual residing in the Commonwealth, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan under Title 38.2.

"Managed care health insurance plan" means an arrangement for the delivery of health care in which a health carrier as defined in § 38.2-5800 undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are ~~directly~~ ~~or~~ ~~indirectly~~ managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers ~~preferred~~ ~~provider~~ ~~contracts~~ ~~or~~ ~~policies~~ ~~as~~ ~~defined~~ ~~in~~ ~~§ 38.2-3407~~ ~~or~~ preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more managed care health insurance plans. *Preferred provider policies or contracts under § 38.2-3407 shall not be managed care health insurance plans.* For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are ~~directly~~ ~~or~~ ~~indirectly~~ managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Managed care health insurance plan licensee" means a health carrier subject to licensure by the Bureau of Insurance under Title 38.2 who is responsible for a managed care health insurance plan in accordance with Chapter 58 (§ 38.2-5801 et seq.) of Title 38.2.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, other organization, partnership, receiver, reciprocal or inter-insurance exchange, trustee or society.

§ 38.2-5800. Definitions.

As used in this chapter:

"Accident and sickness insurance company" means a person subject to licensing in accordance with provisions in Chapter 10 (§ 38.2-1000 et seq.) or Chapter 41 (§ 38.2-4100 et seq.) of this title seeking or having authorization (i) to issue accident and sickness insurance as defined in § 38.2-109, (ii) to issue the benefit certificates or policies of accident and sickness insurance described in § 38.2-3801, or (iii) to provide hospital, medical and nursing benefits pursuant to §§ 38.2-4116 and 38.2-4123.

"Affiliated provider" means any provider that is employed by or has entered into a contractual agreement either directly or indirectly with a health carrier to provide health care services to members of a managed care health insurance plan for which the health carrier is responsible under this chapter.

"Basic health care services" means emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiological services, and preventive health services. "Basic health care services" shall also mean limited treatment of mental illness and substance abuse as set forth

in § 38.2-3412.1 or in the case of a health maintenance organization shall be in accordance with such minimum standards set by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) of this title.

"Copayment" means a payment required of covered persons as a condition of the receipt of specific health services.

"Covered person" means an individual, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan (MCHIP) who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to an MCHIP.

"Evidence of coverage" includes any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health carrier" means an entity subject to Title 38.2 that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including an entity providing a plan of health insurance, health benefits or health services, an accident and sickness insurance company, a health maintenance organization, or a nonstock corporation offering or administering a health services plan, a hospital services plan, or a medical or surgical services plan, or operating a plan subject to regulation under Chapter 45 (§ 38.2-4500 et seq.) of this title.

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.) of this title.

"Limited health care services" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, and such other services as may be determined by the Commission to be limited health care services. Limited health care services shall not include hospital, medical, surgical or emergency services except as such services are provided incident to the limited health care services set forth in the preceding sentence.

"Managed care health insurance plan" or "MCHIP" means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are ~~directly or indirectly~~ managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers ~~preferred provider contracts or policies as defined in § 38.2-3407 or~~ preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more MCHIPs. *Preferred provider policies or contracts under § 38.2-3407 shall not be managed care health insurance plans.* For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are ~~directly or indirectly~~ managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Medical necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"Network" means the set of providers directly or indirectly managed, owned, under contract with or employed directly or indirectly by a health carrier for the purpose of delivering health care services to the covered persons of an MCHIP.

"Provider" or "health care provider" means any hospital, physician, or other person authorized by statute, licensed or certified to furnish health care services.

"Service area" means a clearly defined geographic area in which a health carrier has directly or indirectly arranged for the provision of health care services to be generally available and readily accessible to covered persons of an MCHIP.