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HOUSE BILL NO. 222

Offered January 14, 2004

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A BILL to amend and reenact §§ 32.1-137.1, 38.2-4214, 38.2-4319, 38.2-4509, and 38.2-5800 of the Code of Virginia, relating to exclusion of dental service plans from the definition of managed care health insurance plan.

 Patron—Hargrove

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.1, 38.2-4214, 38.2-4319, 38.2-4509, 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.

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

"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, *as defined in this chapter*, 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 *except to the extent a contract or policy of a health maintenance organization or health carrier provides or arranges for the delivery of dental services only*. 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.

§ 38.2-4214. 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, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 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,

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59 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401,
60 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through
61 38.2-3407.16, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3501,
62 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, § 38.2-3514.1, § 38.2-3514.2,
63 §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through
64 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3543.2, 38.2-3600 through 38.2-3607,
65 Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.)
66 *except for dental services plans*, and § 38.2-5903 of this title shall apply to the operation of a plan.

67 § 38.2-4319. (Effective July 1, 2004) Statutory construction and relationship to other laws.

68 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this
69 chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218
70 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through
71 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.),
72 §§ 38.2-1017 through 38.2-1023, 38.2-1057, Articles 2 (§ 38.2-1306.2 et seq.), 3.1 (§§ 38.2-1316.1 et
73 seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.)
74 and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405,
75 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2,
76 38.2-3411.3, 38.2-3411.4, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.12, 38.2-3418.14, 38.2-3419.1,
77 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504,
78 §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2,
79 Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.)
80 *except for dental services plans*, and § 38.2-5903 of this title shall be applicable to any health
81 maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer
82 or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42
83 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance
84 organization.

85 B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives
86 shall not be construed to violate any provisions of law relating to solicitation or advertising by health
87 professionals.

88 C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful
89 practice of medicine. All health care providers associated with a health maintenance organization shall
90 be subject to all provisions of law.

91 D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health
92 maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to
93 offer coverage to or accept applications from an employee who does not reside within the health
94 maintenance organization's service area.

95 E. For purposes of applying this section, "insurer" when used in a section cited in subsection A of
96 this section shall be construed to mean and include "health maintenance organizations" unless the section
97 cited clearly applies to health maintenance organizations without such construction.

98 § 38.2-4509. Application of certain laws.

99 A. No provision of this title except this chapter and, insofar as they are not inconsistent with this
100 chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229,
101 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,
102 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.)
103 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
104 Chapter 13, §§ 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404,
105 38.2-3405, 38.2-3407.10, 38.2-3407.13, 38.2-3407.14, 38.2-3407.15, 38.2-3415, 38.2-3541, 38.2-3600
106 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) *except for dental*
107 *services plans*, and § 38.2-5903 of this title shall apply to the operation of a plan.

108 B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The
109 provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

110 C. *The provisions of Article 1.1 (§ 32.1-137.1) of Chapter 5 of Title 32.1 shall not apply to a dental*
111 *services plan.* The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not
112 apply to either an optometric or dental services plan.

113 § 38.2-5800. Definitions.

114 As used in this chapter:

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

120 "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, *other than dental 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, *as defined in this chapter*, 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 *except to the extent a contract or policy of a health maintenance organization or health carrier provides or arranges for the delivery of dental services only*. 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.