VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 38.2-4300, 38.2-4301, and 38.2-4302 of the Code of Virginia, relating to health maintenance organizations.

[S 372]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4300, 38.2-4301, and 38.2-4302 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-4300. Definitions.

As used in this chapter:

"Acceptable securities" means securities that (i) are legal investments under the laws of ~~this~~ *the* Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, (iii) have a current market value of not less than $50,000 nor more than $500,000, and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership effected on the records of the depository and its participants pursuant to rules and procedures established by the depository.

"Basic health care services" means in and out-of-area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, and preventive health services. "Basic health care services" shall also mean limited treatment of mental illness and substance abuse in accordance with such minimum standards as may be prescribed 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. In the case of a health maintenance organization that has contracted with ~~this~~ *the* Commonwealth to furnish basic health services to recipients of medical assistance under Title XIX of the United States Social Security Act pursuant to § 38.2-4320, the basic health services to be provided by the health maintenance organization to program recipients may differ from the basic health services required by this section to the extent necessary to meet the benefit standards prescribed by the state plan for medical assistance services authorized pursuant to § 32.1-325.

"Copayment" means an amount an enrollee is required to pay in order to receive a specific health care service.

"Deductible" means an amount an enrollee is required to pay out-of-pocket before the health care plan begins to pay the costs associated with health care services.

"Emergency services" means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate, individual or group agreement or contract, or identification card issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Excess insurance" or "stop loss insurance" means insurance issued to a health maintenance organization by an insurer licensed in ~~this~~ *the* Commonwealth, on a form approved by the Commission, or a risk assumption transaction acceptable to the Commission, providing indemnity or reimbursement against the cost of health care services provided by the health maintenance organization.

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, including emergency services and services rendered by nonparticipating referral providers, as distinguished from mere indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a significant part shall mean at least 90 percent of total costs of health care services.

"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 maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"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.

"Net worth" *or "capital and surplus"* means the excess of total admitted assets over the total liabilities of the health maintenance organization, provided that surplus notes shall be reported and accounted for in accordance with guidance set forth in the National Association of Insurance Commissioners (NAIC) accounting practice and procedures manuals.

"Nonparticipating referral provider" means a provider who is not a participating provider but with whom a health maintenance organization has arranged, through referral by its participating providers, to provide health care services to enrollees. Payment or reimbursement by a health maintenance organization for health care services provided by nonparticipating referral providers may exceed five percent of total costs of health care services, only to the extent that any such excess payment or reimbursement over five percent shall be combined with the costs for services which represent mere indemnification, with the combined amount subject to the combination of limitations set forth in this definition and in this section's definition of health care plan.

"Participating provider" means a provider who has agreed to provide health care services to enrollees and to hold those enrollees harmless from payment with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the health maintenance organization.

"Provider" or "health care provider" means any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services.

"Subscriber" means a contract holder, an individual enrollee, or the enrollee in an enrolled family who is responsible for payment to the health maintenance organization or on whose behalf such payment is made.

§ 38.2-4301. Establishment of health maintenance organizations.

A. No person shall establish or operate a health maintenance organization in ~~this~~ *the* Commonwealth without obtaining a license from the Commission. Any person, including a foreign corporation, may apply to the Commission for a license to establish and operate a health maintenance organization in compliance with this chapter.

B. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:

1. A copy of any basic organizational document of the applicant including, but not limited to, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents;

2. A copy of the bylaws, rules and regulations, or any similar document regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, and official positions, and biographical information on forms acceptable to the Commission of each member of the governing body and any person with authority to manage or establish policy; and a full disclosure in the application of (i) any financial interest between such persons or any provider, organization or corporation owned or controlled by such person and the health maintenance organization and (ii) the extent and nature of the financial arrangements between such persons and the health maintenance organization;

4. A disclosure of any person owning or having the right to acquire five percent or more of the voting securities or subordinated debt of the applicant;

~~4~~ *5.* A copy of any contract made or to be made between any providers, sponsors, or organizers of the health maintenance organization, or persons listed in subdivision 3 of this subsection and the applicant;

~~5~~ *6.* A copy of the evidence of coverage form to be issued to subscribers;

~~6~~ *7.* A copy of any group contract form that is to be issued to employers, unions, trustees, or other organizations. All group contracts shall set forth the right of subscribers to convert their coverages to an individual contract issued by the health maintenance organization;

~~7~~ *8.* Financial statements showing the applicant's assets, liabilities, and sources of financial support and, if the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement unless the Commission directs that additional or more recent financial information is required for the proper administration of this chapter;

~~8~~ *9*. A complete description of the health maintenance organization and its method of operation, including (i) the method of marketing the plan, (ii) a statement regarding the sources of working capital as well as any other sources of funding, and (iii) a description of any insurance, reinsurance, or alternative coverage arrangements proposed, including excess insurance or stop loss insurance;

~~9~~ *10*. A description of the mechanism by which enrollees will be given an opportunity to participate in matters of policy and operation as provided in subsection B of § 38.2-4304;

~~10~~ *11*. A financial feasibility plan which includes, but is not limited to, (i) detailed enrollment projections, (ii) the methodology for determining premium rates to be charged during at least the first three years of operations and extending one year beyond the anticipated break-even point certified by an actuary, and (iii) a projection, along with material assumptions, of balance sheets, cash flow statements showing capital expenditures and purchase and sale of investments, income statements, and statements of anticipated covered and uncovered expenses on a quarterly basis for at least three years and extending one year beyond the anticipated break-even point; and

~~11~~ *12*. Any other information the Commission may require to make the determinations required pursuant to § 38.2-4302.

C. Notwithstanding any other provision of this title, no license shall be required of a health maintenance organization duly licensed in a state contiguous to ~~this~~ *the* Commonwealth that contracts on a limited basis with health care providers in ~~this~~ *the* Commonwealth for the provision of health care services to enrollees covered under a group contract neither delivered nor issued for delivery in ~~this~~ *the* Commonwealth, provided that:

1. The number of Virginia residents receiving such health care services shall not exceed 500 enrollees of such health maintenance organization; and

2. The contracts with such providers shall contain a hold harmless clause that is not less favorable in any respect to any enrollee that is a Virginia resident than the "hold harmless clause" set forth in subdivision C 9 of § 38.2-5805.

§ 38.2-4302. Issuance of license; fee; minimum net worth; impairment.

A. The Commission shall issue a license to a health maintenance organization after the receipt of a complete application and payment of a $500 nonrefundable application fee if the Commission is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and reputable;

2. The health care plan constitutes an appropriate mechanism for the health maintenance organization to provide or arrange for the provision of, as a minimum, basic health care services or limited health care services on a prepaid basis, except to the extent of reasonable requirements for copayments, deductibles, or both;

3. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commission may consider:

a. The financial soundness of the health care plan's arrangements for health care services and the schedule of prepaid charges used for those services;

b. The adequacy of working capital;

c. Any agreement with an insurer, a health services plan, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage if the health care plan is discontinued;

d. Any contracts with health care providers that set forth the health care services to be performed and the providers' responsibilities for fulfilling the health maintenance organization's obligations to its enrollees;

e. The deposit of acceptable securities in an amount satisfactory to the Commission, submitted in accordance with § 38.2-4310 as a guarantee that the obligations to the enrollees will be duly performed;

f. The applicant's net worth which shall include minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than $600,000, up to a maximum of $4 million; uncovered expenses shall be amounts determined from the most recently ended calendar quarter pursuant to regulations promulgated by the Commission; and

g. A financial statement of the health maintenance organization on the form required by § 38.2-4307;

4. The enrollees will be given an opportunity to participate in matters of policy and operation as required by § 38.2-4304; and

5. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-4301 or Chapter 58 (§ 38.2-5800 et seq.) or by independent investigation. Issuance of a license shall not constitute approval of the forms submitted under subdivisions 5, 6, and ~~11~~ *12* of subsection B of § 38.2-4301.

B. A licensed health maintenance organization shall have and maintain at all times the minimum net

worth described in subdivision 3 f of subsection A of this section.

1. If the Commission finds that the minimum net worth of a domestic health maintenance organization is impaired, the Commission shall issue an order requiring the health maintenance organization to eliminate the impairment within a period not exceeding 90 days. The Commission may by order served upon the health maintenance organization prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If at the expiration of the designated period the health maintenance organization has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the health maintenance organization may be entered as provided in § 38.2-4317.

2. If the Commission finds an impairment of the minimum net worth of any foreign health maintenance organization, the Commission may order the health maintenance organization to eliminate the impairment and restore the minimum net worth to the amount required by this section. The Commission may, by order served upon the health maintenance organization, prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If the health maintenance organization fails to comply with the Commission's order within a period of not more than 90 days, the Commission may, in the manner set out in § 38.2-4316, suspend or revoke the license of the health maintenance organization.

3. Prior to December 31, 1999, a health maintenance organization with less than minimum net worth which is licensed on and after June 30, 1998, may continue to operate as a licensed health maintenance organization without a finding of impairment if the licensee has net worth (i) on June 30, 1998, and up to December 31, 1998, in an amount at least equal to the sum of uncovered expenses, but not less than $300,000, up to a maximum of $2 million; (ii) on December 31, 1998, and up to June 30, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $400,000, up to a maximum of $2.5 million; and (iii) on June 30, 1999, and up to December 31, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $500,000, up to a maximum of $3 million.