

## VIRGINIA ACTS OF ASSEMBLY — CHAPTER

*An Act to amend and reenact §§ 38.2-4300, 38.2-4307.1, and 38.2-5800 of the Code of Virginia, relating to the regulation of health maintenance organizations.*

[H 1044]

Approved

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 38.2-4300, 38.2-4307.1, and 38.2-5800 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 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 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, or 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 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.

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

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

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

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

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

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

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

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

86 § 38.2-4307.1. Additional reports.

87 A. In addition to the annual statement, the Commission may require a licensed health maintenance  
88 organization to file additional reports, exhibits or statements considered necessary to secure complete  
89 information concerning the condition, solvency, experience, transactions or affairs of the health  
90 maintenance organization. The Commission shall establish reasonable deadlines for filing these  
91 additional reports, exhibits, or statements and may require verification by any officers of the health  
92 maintenance organization designated by the Commission.

93 B. The Commission may require a licensed health maintenance organization to file with the National  
94 Association of Insurance Commissioners (NAIC) a copy of its financial statement required to be filed  
95 pursuant to § 38.2-4307, on a quarterly basis. Unless otherwise prescribed by the Commission, all such  
96 financial statements, whether filed with the Commission or the NAIC, shall be prepared in accordance  
97 with applicable provisions of the annual statement instructions and the accounting practices and  
98 procedures manual adopted by the NAIC, or any successor publications. The Commission may prescribe  
99 that additional copies of financial statements and other reports be filed in machine-readable format.

100 C. Each annual and quarterly statement shall be accompanied by a statement of covered and  
101 uncovered expenses. The statement shall be prepared in accordance with instructions prescribed by the  
102 Commission for reporting the expenses of the health maintenance organization during the three months  
103 comprising the most recently ended calendar-year quarter. *The statement of covered and uncovered*  
104 *expenses shall not be required for any health maintenance organization that reports a capital and*  
105 *surplus amount of at least \$4,500,000 on its most recent annual or quarterly financial statement filed*  
106 *with the Commission.*

107 § 38.2-5800. Definitions.

108 As used in this chapter:

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

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

117 "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. 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.