VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 8.01-27.5, 38.2-2201, 38.2-3407.12, and 38.2-3407.15 of the Code of Virginia, relating to health care policy, group health benefit plan, and health plan; definitions.

[S 360]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-27.5, 38.2-2201, 38.2-3407.12, and 38.2-3407.15 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-27.5. Duty of in-network providers to submit claims to health insurers; liability of covered patients for unbilled health care services.

A. As used in this section:

"Covered patient" means a patient whose health care services are covered under terms of a health care policy.

"Health care policy" means any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, offered, arranged, issued, or administered by a health insurer to an individual or a group contract holder to cover all or a portion of the cost of individuals, or their eligible dependents, receiving covered health care services. "Health care policy" includes coverages issued pursuant to (i) Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (ii) § 2.2-1204 (local choice); (iii) 5 U.S.C. § 8901 et seq. (federal employees); and (iv) an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1) of the Employee Retirement Income Security Act of 1974 (ERISA) that is self-insured or self-funded. "Health care policy" does not include (a) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. *(Medicaid)*, or Title ~~XX~~ *XXI* of the Social Security Act, 42 U.S.C. § ~~1397~~ *1397aa* et seq. ~~(Medicaid)~~ *(CHIP)*, or Chapter 55 of Title 10 of the United States Code, 10 U.S.C. § 1071 et seq. (TRICARE); (b) subscription contracts for one or more dental or optometric services plans that are subject to Chapter 45 (§ 38.2-4500 et seq.) of Title 38.2; (c) insurance policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents, including student accident, sports accident, blanket accident, specific accident, and accidental death and dismemberment policies; (d) credit life insurance and credit accident and sickness insurance issued pursuant to Chapter 37.1 (§ 38.2-3717 et seq.) of Title 38.2; (e) insurance policies that provide payments when an insured is disabled or unable to work because of illness, disease, or injury, including incidental benefits; (f) long-term care insurance as defined in § 38.2-5200; (g) plans providing only limited health care services under § 38.2-4300 unless offered by endorsement or rider to a group health benefit plan; (h) TRICARE supplement, Medicare supplement, or workers' compensation coverages; or (i) medical expense coverage issued pursuant to § 38.2-2201.

"Health care provider" has the same meaning ascribed to the term in § 8.01-581.1.

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

"Health insurer" means any entity that is the issuer or sponsor of a health care policy.

"In-network provider" means a health care provider that is employed by or has entered into a provider agreement with the health insurer that has issued the health care policy, under which agreement the health care provider has agreed to provide health care services to covered patients.

"Patient" means an individual who receives health care services from a health care provider, or any person authorized by law to consent on behalf of the individual incapable of making an informed decision, or, in the case of a minor child, the parent or parents having custody of the child or the child's legal guardian, or as otherwise provided by law.

"Provider agreement" means a contract, agreement, or arrangement between a health care provider and a health insurer, or a health insurer's network, provider panel, intermediary, or representative, under which the health care provider has agreed to provide health care services to patients with coverage under a health care policy issued by the health insurer and to accept payment from the health insurer for the health care services provided.

B. An in-network provider that provides health care services to a covered patient shall submit its claim to the health insurer for the health care services in accordance with the terms of the applicable

provider agreement, provided that the covered patient provides the in-network provider with information required by the terms of the covered patient's health care policy's plan documents, including the information that is required to verify the individual's coverage under the health care policy, within not fewer than 21 business days before the deadline for the in-network provider to submit its claim to the health insurer as required by the terms of the provider agreement. If an in-network provider does not submit its claim to the health insurer in accordance with the requirements of this subsection, then (i) the covered patient shall have no obligation to pay for health care services for which the in-network provider was required to submit its claim, (ii) the in-network provider shall not have the benefit of the liens provided by §§ 8.01-66.2 and 8.01-66.9 with regard to health care services for which the in-network provider was required to submit its claim, and (iii) the in-network provider shall be prohibited from recovering payment for any of the health care services for which it was required to submit its claim from an insurer providing medical expense benefits to the covered patient under a policy of motor vehicle liability insurance pursuant to § 38.2-2201, by exercising an assignment of the covered patient's rights to the medical expense benefits or by other means. If the in-network provider submits its claim to the health insurer in accordance with the requirements of this subsection, the covered patient or the health insurer shall be obligated to pay for the health care services in accordance with the terms of the provider agreement or health care policy's plan documents. To the extent that self-insured or self-funded plans governed by ERISA provide otherwise, health care providers shall be permitted to submit claims and coordinate benefits as provided for in the provider agreements or plan documents.

§ 38.2-2201. Provisions for payment of medical expense and loss of income benefits; assignment of certain benefits.

A. Upon request of an insured, each insurer licensed in this Commonwealth issuing or delivering any policy or contract of bodily injury or property damage liability insurance covering liability arising from the ownership, maintenance or use of any motor vehicle shall provide on payment of the premium, as a minimum coverage (i) to persons occupying the insured motor vehicle; and (ii) to the named insured and, while resident of the named insured's household, the spouse and relatives of the named insured while in or upon, entering or alighting from or through being struck by a motor vehicle while not occupying a motor vehicle, the following health care and disability benefits for each accident:

1. All reasonable and necessary expenses for medical, chiropractic, hospital, dental, surgical, ambulance, prosthetic and rehabilitation services, and funeral expenses, resulting from the accident and incurred within three years after the date of the accident, up to $2,000 per person; however, if the insured does not elect to purchase such limit the insurer and insured may agree to any other limit;

2. If the person is usually engaged in a remunerative occupation, an amount equal to the loss of income incurred after the date of the accident resulting from injuries received in the accident up to $100 per week during the period from the first workday lost as a result of the accident up to the date the person is able to return to his usual occupation. However, the period shall not extend beyond one year from the date of the accident; and

3. An expense described in subdivision 1 shall be deemed to have been incurred:

a. If the insured is directly responsible for payment of the expense;

b. If the expense is paid by (i) a health care insurer pursuant to a negotiated contract with the health care provider or (ii) Medicaid or Medicare, where the actual payment with reference to the medical bill rendered by the provider is less than or equal to the provider's usual and customary fee, in the amount of the actual payment as evidenced by an explanation of benefits, remittance advice, or similar documentation from the health care provider; however, if the insured is required to make a payment in addition to the actual payment by the health care insurer or Medicaid or Medicare, the amount shall be increased by the payment made by the insured; or

c. If no medical bill is rendered or specific charge made by a health care provider to the insured, an insurer, or any other person, in the amount of the usual and customary fee charged in that community for the service rendered.

B. The insured has the option of purchasing either or both of the coverages set forth in subdivisions A 1 and A 2. Either or both of the coverages, as well as any other medical expense or loss of income coverage under any policy of automobile liability insurance, shall be payable to the covered injured person or pursuant to an assignment of benefits in accordance with subsection D, notwithstanding the failure or refusal of the named insured or other person entitled to the coverage to give notice to the insurer of an accident as soon as practicable under the terms of the policy, except where the failure or refusal prejudices the insurer in establishing the validity of the claim.

C. In any policy of personal automobile insurance in which the insured has purchased coverage under subsection A, every insurer providing such coverage arising from the ownership, maintenance or use of no more than four motor vehicles shall be liable to pay up to the maximum policy limit available on every motor vehicle insured under that coverage if the health care or disability expenses and costs

mentioned in subsection A exceed the limits of coverage for any one motor vehicle so insured.

D. Any attempt to assign medical expense benefits shall be subject to the following:

1. An assignment of medical expense benefits shall be valid only if:

a. A copy of the AOB form, executed by the assignor and in compliance with the other requirements of subdivision D 1 and a copy of the notice complying with subdivision g if such notice is provided in a separate document pursuant to subdivision e, is provided to the motor vehicle insurer;

b. The AOB form is (i) in writing, which includes any printed or electronic format, (ii) dated, and (iii) executed by the assignor;

c. The AOB form includes a conspicuous statement that the assignor is not required to execute the AOB form;

d. If the AOB form includes a notice that complies with the provisions of subdivision g, the AOB form is signed, initialed, or otherwise marked by the assignor, at or near the notice provision, to acknowledge that the assignor has read, or had the opportunity to read, the notice;

e. If the AOB form does not include a notice that complies with the provisions of subdivision g, (i) the assignor is given a separate document, in any printed or electronic format, that is delivered to the assignor at the same time as the AOB form and that contains a notice that complies with the provisions of subdivision g; (ii) the AOB form includes a conspicuous statement that a notice regarding the assignment of medical expense benefits is provided in a separate document; and (iii) the AOB form is signed, initialed, or otherwise marked by the assignor at or near the statement described in clause (ii) to acknowledge that the assignor has read, or had the opportunity to read, the separate document containing the notice;

f. The statements required by subdivision D 1 to be included in the AOB form or a separate document, including the notice prescribed by subdivision g, are in not less than eight-point type; and

g. The assignor is provided, either in the AOB form or in a separate document, a notice that summarizes the effect of the assignment of medical expense benefits, which notice states the following:

"Notice: automobile accident patients

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: as long as you provide information necessary to verify your health insurance coverage the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network: your health care provider may bill their full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care.";

2. Upon receipt of a copy of an AOB form that satisfies the requirements of subdivision D 1 and (i) an explanation of benefits or remittance advice or (ii) a bill, claim form, or documentation from the assignee advising that it has been represented to the assignee that the covered injured person does not have health insurance or is covered by a self-insured or self-funded employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 which requires medical expense coverage to be primary, a motor vehicle insurer shall pay directly to the health care provider, from any medical expense benefits available to such person under a motor vehicle insurance policy:

a. If the covered injured person is covered under a health care policy, the health care provider is an in-network provider, and the health care provider has submitted its claim to the health insurer for the health care services, the amount of any copayments, coinsurance, or deductibles owed by the injured covered person to the health care provider, as evidenced by an explanation of benefits, remittance advice, or similar documentation provided to the motor vehicle insurer; or

b. If (i) the covered injured person is not covered under a health care policy, (ii) the covered injured person is covered by a self-insured or self-funded employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 which requires medical expense coverage to be primary, or (iii) the health care provider is not an in-network provider, amounts to cover the cost of the health care services provided, in the amount of the usual and customary fee charged in that community for the health care services rendered;

3. A motor vehicle insurer shall in all respects be held harmless for making payments pursuant to subdivision D 2 to a health care provider in accordance with an assignment of benefits that satisfies the requirements of subdivision D 1;

4. A covered injured person shall not be required to assign to any person any medical expense

benefits he may have under this section, including any assignment of the proceeds of such coverages;

5. An assignment of medical expense benefits shall be void and unenforceable as against public policy if the assignment does not comply with the requirements of subdivision D 1;

6. Medical expense benefits may not be reduced because of any benefits paid, payable, or provided by any insurance contract providing hospital, medical, surgical, and similar or related benefits, or any subscription contract or health services plan delivered or issued for delivery or providing for the payment of benefits to or on behalf of persons residing in or employed in the Commonwealth, except as authorized by this section; and

7. Nothing in this section shall prohibit the payment of medical expense benefits due to the covered injured person directly to any state or federal assistance program that has provided medical benefits to such injured person when the injury arose out of the ownership, maintenance, or use of any motor vehicle.

E. As used in subsection D:

"AOB form" means the document or instrument that contains a provision by which the assignor assigns medical expense benefits, including any assignment of the proceeds of such coverages, to an assignee. The AOB form may be a separate instrument or included in another instrument, including a consent form or a form assigning other benefits.

"Assignee" means the health care provider to which the assignor is assigning medical expense benefits, including any assignment of the proceeds of such coverages.

"Assignor" means the covered injured person or a person authorized to consent on the covered injured person's behalf.

"Health care policy" means any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, offered, arranged, issued, or administered by a health insurer to an individual or a group contract holder to cover all or a portion of the cost of individuals, or their eligible dependents, receiving covered health care services. Health care policy includes coverages issued pursuant to (i) Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (ii) § 2.2-1204 (local choice); (iii) 5 U.S.C. § 8901 et seq. (federal employees); and (iv) an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1) of the Employee Retirement Income Security Act of 1974 that is self-insured or self-funded. Health care policy does not include (a) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare); Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. *(Medicaid)*, or Title ~~XX~~ *XXI* of the Social Security Act, 42 U.S.C. § ~~1397~~ *1397aa* et seq. ~~(Medicaid)~~ *(CHIP)*; or Chapter 55 of Title 10 of the United States Code, 10 U.S.C. § 1071 et seq. (TRICARE); (b) subscription contracts for one or more dental or optometric services plans that are subject to Chapter 45 (§ 38.2-4500 et seq.); (c) insurance policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents, including student accident, sports accident, blanket accident, specific accident, and accidental death and dismemberment policies; (d) credit life insurance and credit accident and sickness insurance issued pursuant to Chapter 37.1 (§ 38.2-3717 et seq.) of Title 38.2; (e) insurance policies that provide payments when an insured is disabled or unable to work because of illness, disease, or injury, including incidental benefits; (f) long-term care insurance as defined in § 38.2-5200; (g) plans providing only limited health care services under § 38.2-4300 unless offered by endorsement or rider to a group health benefit plan; (h) TRICARE supplement, Medicare supplement, and workers' compensation coverages; or (i) medical expense coverage issued pursuant to this section.

"Health care provider" has the same meaning that is ascribed to that term in § 8.01-581.1.

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

"Health insurer" means any entity that is the issuer or sponsor of a health care policy.

"In-network provider" means a health care provider that is employed by or has entered into a provider agreement with the health insurer that has issued the health care policy, under which applicable agreement the health care provider has agreed to provide health care services to covered patients.

"Medical expense benefits" means the benefits of coverages described in subdivision A 1, including any assignment of the proceeds of such coverages.

"Motor vehicle insurer" means the insurer issuing or delivering a policy or contract covering liability arising from the ownership, maintenance, or use of any motor vehicle that provides coverage for medical expense benefits.

"Person authorized to consent on the covered injured person's behalf" means any person authorized by law to consent on behalf of the covered injured person incapable of making an informed decision or, in the case of a minor child, the parent or parents having custody of the child or the child's legal guardian or as otherwise provided by law.

"Provider agreement" means a contract, agreement, or arrangement between a health care provider and a health insurer, or a health insurer's network, provider panel, intermediary, or representative, under which the health care provider has agreed to provide health care services to patients with coverage under a health care policy issued by the health insurer and to accept payment from the health insurer for the health care services provided.

§ 38.2-3407.12. Patient optional point-of-service benefit.

A. As used in this section:

"Affiliate" shall have the meaning set forth in § 38.2-1322.

"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;

2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services plans which are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;

3. Any health maintenance organization licensed under this title which provides or arranges for the provision of one or more health care plans which are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;

4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans which are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and

5. Any other person licensed under this title which provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels which are subject to regulation as the business of insurance under this title.

"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service which is not paid by the carrier and for which the enrollee is responsible.

"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the enrollee to the provider towards the allowable charge as a condition of the receipt of specific health care items and services.

"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the enrollee as a condition to or consequence of the receipt of covered items or services.

"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.

"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.

"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.

"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. *(Medicaid)* or Title ~~XX~~ *XXI* of the Social Security Act, 42 U.S.C. § ~~1397~~ *1397aa* et seq. ~~(Medicaid)~~ *(CHIP)*, 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. ~~(CHAMPUS)~~ *(TRICARE)* or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), ~~CHAMPUS~~ *TRICARE* supplement, Medicare supplement, or workers' compensation coverages; or (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded.

"Group specific administrative cost" means the direct administrative cost incurred by a carrier related

to the offer of the point-of-service benefit to a particular group contract holder.

"Health care plan" shall have the meaning set forth in § 38.2-4300.

"Person" means any individual, corporation, trust, association, partnership, limited liability company, organization or other entity.

"Point-of-service benefit" means a health maintenance organization's delivery system or covered benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with the health maintenance organization, which permit an enrollee (and eligible dependents) to receive covered items and services outside of the provider panel, including optometrists and clinical psychologists, of the health maintenance organization under the terms and conditions of the group contract holder's group health benefit plan with the health maintenance organization or with another carrier arranged by or under contract with the health maintenance organization and which otherwise complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee (and eligible dependents) to receive the full range of covered items and services outside of a provider panel, including optometrists and clinical psychologists, and which are otherwise in compliance with applicable law and this section shall constitute a point-of-service benefit.

"Preferred provider organization plan" means a health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209.

"Provider" means any physician, hospital or other person, including optometrists and clinical psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health care items or services.

"Provider panel" means the participating providers or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health maintenance organization or other carrier.

B. To the maximum extent permitted by applicable law, every health care plan offered or proposed to be offered in this Commonwealth by a health maintenance organization licensed under this title to a group contract holder shall provide or include, or the health maintenance organization shall arrange for or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered in conjunction with the health maintenance organization's health care plan as an additional benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every health maintenance organization shall, at no additional cost to the group contract holder, make available or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance acceptable to the Commission which accurately and completely explains to the group contract holder and prospective enrollee the point-of-service benefit and permits each enrollee to make his or her election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the carrier in any reasonable manner.

C. To the extent permitted under applicable law, a health maintenance organization providing or arranging, or contracting with another carrier to provide, the point-of-service benefit under this section and a carrier providing the point-of-service benefit required under this section under arrangement or contract with a health maintenance organization:

1. May not impose, or permit to be imposed, a minimum enrollee participation level on the point-of-service benefit alone;

2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or 38.2-4221 for items or services provided under the point-of-service benefit required under this section solely on the basis of the license or certification of the provider to provide such items or services if the carrier otherwise covers the items or services provided and the provision of the items or services is within the provider's lawful scope of practice or authority; and

3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group prior to any enrollee electing to accept or reject the point-of-service benefit.

D. The premium imposed by a carrier with respect to enrollees who select the point-of-service benefit may be different from that imposed by the health maintenance organization with respect to enrollees who do not select the point-of-service benefit. Unless a group contract holder determines otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of any premium over the amount of the premium applicable to an enrollee who selects the coverage offered

by the health maintenance organization without the point-of-service benefit and for any identifiable group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization; provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) thirty percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service benefit any condition or penalty designed to discourage the enrollee's selection or use of the point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

H. Except as expressly otherwise permitted in this section or as otherwise required under applicable law, the scope of the health care items and services which are covered under the point-of-service benefit required under this section shall at least include the same health care items and services which would be covered if provided under the health maintenance organization's health care plan, including without limitation any items or services covered under a rider or endorsement to the applicable health care plan. Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing materials utilized with respect to such group health benefit plans that the scope of the benefits provided under the point-of-service option are at least as great as those provided through the HMO's health care plan for that group. Filings of point-of-service benefits submitted to the Commission shall be accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the point-of-service benefits includes at a minimum the same health care items and services as are provided under the HMO's group health care plan for that group.

I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the health maintenance organization's group health benefit plan which does not contain the point-of-service benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is offered in a manner which separates or otherwise differentiates it from the group health benefit plan which does not contain the point-of-service benefit.

J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit under this section with respect to any group health benefit plan offered to a group contract holder if the health maintenance organization determines in good faith that the group contract holder will be concurrently offering another group health benefit plan or a self-insured or self-funded health benefit plan which allows the enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization's panel.

K. This section shall apply only to group health benefit plans issued in the Commonwealth in the commercial group market by carriers regulated by this title and shall not apply to (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. *(Medicaid)* or Title ~~XX~~ *XXI* of the Social Security Act, 42 U.S.C. § ~~1397~~ *1397aa* et seq. ~~(Medicaid)~~ *(CHIP)*, 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. ~~(CHAMPUS)~~ *(TRICARE)* or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), ~~CHAMPUS~~ *TRICARE* supplement, Medicare supplement, or workers' compensation coverages; or (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded.

L. This section shall apply to group health benefit plans issued or renewed by carriers in this Commonwealth on or after July 1, 1998.

M. Nothing in this section shall operate to limit any rights or obligations arising under § 38.2-3407, 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312, or 38.2-4312.1.

N. If any provision of this section or its application to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity shall not affect the other provisions or any other application of this section which shall be given effect without the invalid provision or application, and for this purpose the provisions of this section are declared severable.

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) of this title or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of

preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. *(Medicaid)* or Title ~~XX~~ *XXI* of the Social Security Act, 42 U.S.C. § ~~1397~~ *1397aa* et seq. ~~(Medicaid)~~ *(CHIP)*, 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. ~~CHAMPUS~~ *TRICARE*; or (ii) accident only, credit or disability insurance, long-term care insurance, ~~CHAMPUS~~ *TRICARE* supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1 of this title, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or

downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (i) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (ii) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

6. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

7. Notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

8. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4 of this subsection) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

10. In the event that the carrier's provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make

this information available to providers.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and B 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title.

H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

I. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

J. If any provision of this section, or the application thereof to any person or circumstance, is held invalid or unenforceable, such determination shall not affect the provisions or applications of this section which can be given effect without the invalid or unenforceable provision or application, and to that end the provisions of this section are severable.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.