LD1575828

HOUSE BILL NO. 1969

Offered January 20, 1995

A BILL to amend and reenact §§ 38.2-3407 and 38.2-4209 of the Code of Virginia, relating to accident and sickness insurance; preferred providers.

Patrons—DeBoer and Connally; Senators: Lambert and Schewel

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3407 and 38.2-4209 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3407. Health benefit programs.

A. One or more insurers may offer ~~or administer~~ a health benefit program under which the insurer or insurers ~~may~~ offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. *Insurers shall make such terms and conditions available to the public upon written request. Insurers shall not be required to disclose terms and conditions which contain confidential or proprietary information.* Neither differences in ~~prices~~ *fees* among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or ~~price~~ *fee* differences among providers in different geographical areas, shall be deemed unreasonable discrimination. ~~The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.~~

C. For the purposes of this section, "preferred provider networks" include hospitals, physicians or types of providers listed in § 38.2-3408 with whom an insurer contracts to provide health care or mental health care services through a preferred provider health benefit program. Any such insurer which offers a health benefit program as provided in subsection A shall establish and use preferred provider networks in accordance with the following requirements:

1. Notice of the development of each preferred provider network shall be published in a newspaper or newspapers of general circulation for each area in which the preferred provider network will operate so as to provide reasonable notice to the maximum number of providers that reasonably can be anticipated to submit applications for inclusion in the network. In addition, insurers shall provide a preferred provider application and the relevant terms and conditions to a provider upon request.

2. All preferred provider applications or proposals submitted in accordance with the format and procedure prescribed by the insurer shall be given reasonable consideration. All preferred provider applications shall be reviewed according to the insurer's terms and conditions established pursuant to subsection B.

3. Providers who submit a complete preferred provider application shall be notified, in writing, of the insurer's decision regarding acceptance or denial. For providers not accepted into the preferred provider network, such notice shall include the reason or reasons for the insurer's decision.

4. An internal review process shall be established whereby, upon written request, a provider who is not accepted into the preferred provider network may request a review of his application. Such request for review shall be made by a provider within thirty days of receipt of the insurer's decision. The review shall be conducted on behalf of the insurer by individuals (i) who did not participate in making the decision being reviewed, and (ii) who are at higher management levels than the individuals who rendered such decision. The Insurers shall respond in writing to the provider within thirty days of receipt of a provider's written request for review, advising the provider of the results thereof.

D. The Commission shall have no jurisdiction to adjudicate controversies growing out of subsections B and C.

~~C~~*E*. Mandated types of providers set forth in § 38.2-3408, and types of providers whose services are required to be made available and that have been specifically contracted for by the holder of any such policy or contract shall, to the extent required by § 38.2-3408, have the same opportunity to qualify for payment as a preferred provider as do doctors of medicine.

~~D~~*F*. Preferred provider policies or contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

~~E~~*G*. For the purposes of this section, "preferred provider policies or contracts" are insurance policies

or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.

§ 38.2-4209. Preferred provider subscription contracts.

A. As used in this section, a "preferred provider subscription contract" is a contract that specifies how services are to be covered when rendered by providers participating in a plan, by nonparticipating providers, and by preferred providers.

B. Notwithstanding the provisions of §§ 38.2-4218 and 38.2-4221, any nonstock corporation may, as a feature of its plan, offer preferred provider subscription contracts pursuant to the requirements of this section that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or other type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded. *Nonstock corporations shall make such terms and conditions available to the public upon written request. Nonstock corporations are not required to disclose terms and conditions which contain confidential or proprietary information.* Differences in ~~prices~~ *fees* among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or ~~price~~ *fee* differences among providers in different geographical areas shall not be deemed unreasonable discrimination. ~~The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.~~

D. For the purposes of this section, "preferred provider networks" include hospitals, physicians or types of providers listed in § 38.2-4221 with whom a nonstock corporation contracts to provide health care or mental health care services through a preferred provider subscription contract. Any such nonstock corporation which offers or administers a preferred provider subscription contract as provided in subsection B shall establish and use preferred provider networks in accordance with the following requirements:

1. Notice of the development of each preferred provider network shall be published in a newspaper or newspapers of general circulation for each area in which the preferred provider network will operate so as to provide reasonable notice to the maximum number of providers that reasonably can be anticipated to submit applications for inclusion in the network. In addition, nonstock corporations shall provide a preferred provider application and the relevant terms and conditions to a provider upon request.

2. All preferred provider applications submitted in accordance with the format and procedure prescribed by the nonstock corporation shall be given reasonable consideration. All preferred provider applications shall be reviewed according to the nonstock corporation's terms and conditions established pursuant to subsection C.

3. Providers who submit a complete preferred provider application shall be notified, in writing, of the nonstock corporation's decision regarding acceptance or denial. For providers not accepted into the preferred provider network, such notice shall include the reason or reasons for the nonstock corporation's decision.

4. An internal review process shall be established whereby, upon written request, a provider who is not accepted into the preferred provider network may request a review of his application. Such request for review shall be made by a provider within thirty days of receipt of the nonstock corporation's decision. The review shall be conducted on behalf of the nonstock corporation by individuals (i) who did not participate in making the decision being reviewed, and (ii) who are at higher management levels than the individuals who rendered such decision. Nonstock corporations shall respond in writing to the provider within thirty days of receipt of a provider's written request for review, advising the provider of the results thereof.

E. The Commission shall have no jurisdiction to adjudicate controversies growing out of subsections C and D.

~~D~~*F*. Mandated types of providers listed in § 38.2-4221 and types of providers whose services are required to be made available and which have been specifically contracted for by the holder of any subscription contract shall, to the extent required by § 38.2-4221, have the same opportunity as do doctors of medicine to qualify for payment as preferred providers.

~~E~~*G*. Preferred provider subscription contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.