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HOUSE BILL NO. 1075

House Amendments in [] — February 17, 1998

A *BILL to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.12, relating to health care coverage; point-of-service plans.*

Patrons—Melvin and Morgan; Senators: Gartlan and Lambert

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.12 as follows:

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

A. It is the policy of the Commonwealth that all Virginians with group health care coverage subject to regulation under this title should have access to group health benefit plans which allow the enrollee to access care from their provider of choice, and it is the intent of this section to regulate the business of insurance to promote choice and quality of care and to prohibit unreasonable restrictions on access to appropriate providers without additional cost to or burden on group contract holders.

B. 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

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HB1075E

60 coverage, certificate, health services plan, medical or hospital services plan, accident and sickness
61 insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any
62 endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to
63 cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health
64 care items or services. Group health benefit plan does not mean (i) health care plans, contracts or
65 policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social
66 Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396
67 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et
68 seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 2 (§ 2.1-11.1 et seq.) of Title
69 2.1 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance,
70 plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or
71 rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers'
72 compensation coverages; [~~or~~] (iv) an employee welfare benefit plan (as defined in section 3 (1) of the
73 Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or
74 self-funded [; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431
75 C] .

76 "Group specific administrative cost" means the direct administrative cost incurred by a carrier
77 related to the offer of the point-of-service benefit to a particular group contract holder.

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

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

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

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

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

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

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

120 D. To the extent permitted under applicable law, a health maintenance organization providing or
121 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.

E. 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 [; as may be determined by in a form acceptable to] the Commission.

F. 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.

G. 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

183 affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges
184 another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

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

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

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

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

218 K. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable
219 law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit
220 under this section with respect to any group health benefit plan offered to a group contract holder if the
221 health maintenance organization determines in good faith that the group contract holder will be
222 concurrently offering another group health benefit plan which provides a point-of-service benefit to
223 enrollees.

224 L. This section shall apply only to group health benefit plans issued in the Commonwealth in the
225 commercial group market by carriers regulated by this title and shall not apply to (i) health care plans,
226 contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the
227 Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C.
228 § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C.
229 § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 2 (§ 2.1-11.1 et
230 seq.) of Title 2.1 (state employees); (iii) accident only, credit or disability insurance, or long-term care
231 insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by
232 endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or
233 workers' compensation coverages; [~~or~~] (iv) an employee welfare benefit plan (as defined in section 3
234 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is
235 self-insured or self-funded [; or (v) the essential and standard health benefit plans developed pursuant
236 to § 38.2-3431 C] .

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

239 N. Nothing in this section shall operate to limit any rights or obligations arising under §§ 38.2-3407,
240 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.

241 [~~Ø. The Commission may issue regulations consistent with this section to address disclosure and~~
242 ~~notices, certifications, premiums and cost sharing, administrative costs and other issues necessary to~~
243 ~~ensure the proper implementation of this section.~~]

244 [~~P. O.~~] 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.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 54 (§ 38.2-5400 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

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

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

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