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HOUSE BILL NO. 146

Offered January 12, 2022

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A BILL to amend and reenact §§ 38.2-1317, 38.2-1317.2, 38.2-1320.3, 38.2-3407.10, and 38.2-3407.14 of the Code of Virginia, relating to insurance; examinations; health care provider panels.

Patron—Head

Committee Referral Pending

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-1317, 38.2-1317.2, 38.2-1320.3, 38.2-3407.10, and 38.2-3407.14 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-1317. Examinations; when authorized or required.

A. Whenever the Commission considers it expedient for the protection of the interests of the people of this Commonwealth, it may make or direct to be made an examination into the affairs of any person licensed to transact any insurance business in this Commonwealth or any other person subject to the jurisdiction of the Commission pursuant to provisions of this title. The Commission may also make or direct to be made, whenever necessary or advisable an examination into the affairs of:

1. Any person having a contract under which he has the exclusive or dominant right to manage or control any licensed insurer,

2. Any person holding the shares of capital stock or policyholder proxies of any domestic insurer amounting to control as defined in § 38.2-1322 either as voting trustee or otherwise,

3. Any person engaged or assisting in, or proposing or claiming to engage or assist in the promotion or formation of a domestic insurer, or

4. Any person seeking a license to transact any insurance business in this Commonwealth.

B. The Commission shall examine or cause to be examined every domestic insurer at least once in every five years; however, on or after January 1, 1993, the Commission shall examine every insurer licensed in this Commonwealth at least once in every five years.

C. *Additionally, the Commission shall examine the business and affairs of an insurer upon (i) request by a statewide association representing health care professionals affirming no less than 10 complaints alleging insurer misconduct in a six-month period from providers participating in such insurer's network or (ii) verifiable information that such insurer has violated any law, regulation, or prior order of the Commission. No more than one examination under the provisions of this subsection shall be required in any 12-month period for the same or a substantially similar violation.*

D. The examination of any foreign or alien insurer or any other foreign or alien person subject to examination shall be made to the extent practicable in cooperation with the insurance departments of other states.

~~D.~~ *E.* Instead of making its own examination, the Commission may accept a full report of the examination of a foreign or alien person, duly authenticated by the insurance supervisory official of the state of domicile or of entry until January 1, 1994. Thereafter, such reports may only be accepted if:

1. The insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' (NAIC) Financial Regulation Standards and Accreditation Program;

2. The examination is performed under the supervision of such an accredited insurance department or with the participation of one or more examiners who are employed by an accredited insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department; or

3. The Commission determines, in its sole discretion, that the examination was performed in a manner consistent with standards and procedures employed by the Commission in the examination of domestic insurers, and the report of examination is duly authenticated by the insurance supervisory official of the insurer's state of domicile or entry.

§ 38.2-1317.2. Market analyses confidential.

A. All market analyses concerning companies or insurance transactions that are obtained by the Commission from the NAIC, including information generated by any NAIC databases developed for use by regulators, and all market analyses generated by the Commission based on documents or information submitted to the Commission by a company or person, including its officers, directors, and agents, shall receive confidential treatment by the Commission, shall not be subject to subpoena, and are not public

records. All working papers, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the Commission or any other person in the course of a market analysis or market conduct action shall receive confidential treatment by the Commission, shall not be subject to subpoena, and are not public records. Any such disclosure to the Commission shall not constitute a waiver of confidentiality of any such documents or information.

B. Notwithstanding other provisions to the contrary, nothing shall prevent or be construed as prohibiting the Commission from disclosing otherwise confidential information, administrative or judicial orders, or the content of any analysis or any matter related thereto, at any time to (i) a regulatory official of any state or country; (ii) the NAIC, its affiliate or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those officials are required under their law to maintain its confidentiality. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of any such documents or information.

C. Documents or information received in the course of a market analysis or market conduct action from the NAIC, a law-enforcement official of any state or country, or regulatory officials of any state or country that are confidential in those jurisdictions shall receive confidential treatment by the Commission, shall not be subject to subpoena, and are not public records.

D. Nothing in this section shall prohibit the Commission from releasing a report containing aggregated findings *or fully executed stipulations, orders, decisions, corrective action plans, settlements, or other forms of agreement resulting from an examination*.

§ 38.2-1320.3. Examination reports; orders and procedures.

A. A certified copy of the examination report filed pursuant to subdivision 1 of § 38.2-1320.2 shall be served upon the company by certified mail. Within thirty days of the filing of the report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the filed report and any related orders.

B. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Commission, the Commission may order the company to take any action the Commission considers necessary and appropriate to cure such violation. *The Commission shall publish a reasonably detailed summary of each violation and any corrective action plan on the Commission website within 60 days of the completion of the examination.*

C. Any hearing conducted by the Commission under subdivision 2 of § 38.2-1320.1 or subdivision 3 of § 38.2-1320.2 shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the examination report or raised by or as a result of the Commission's review of relevant workpapers or by the written submission of the company.

§ 38.2-3407.10. Health care provider panels.

A. As used in this section:

"Carrier" means:

1. Any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;

2. Any corporation providing individual or group accident and sickness subscription contracts;

3. Any health maintenance organization providing health care plans for health care services;

4. Any corporation offering prepaid dental or optometric services plans; or

5. Any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

"Enrollee" means any person entitled to health care services from a carrier.

"Provider" means a hospital, physician or any type of provider licensed, certified or authorized by statute to provide a covered service under the health benefit plan.

"Provider panel" means those providers with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan. However, such term does not include an arrangement between a carrier and providers in which any provider may participate solely on the basis of the provider's contracting with the carrier to provide services at a discounted fee-for-service rate.

B. Any such carrier that offers a provider panel shall establish and use it in accordance with the following requirements:

1. Notice of the development of a provider panel in the Commonwealth or local service area shall be filed with the Department of Health Professions.

2. Carriers shall provide a provider application and the relevant terms and conditions to a provider upon request.

C. A carrier that uses a provider panel shall establish procedures for:

1. Notifying an enrollee of:

a. The termination from the carrier's provider panel of the enrollee's primary care provider who was furnishing health care services to the enrollee; and

b. The right of an enrollee upon request to continue to receive health care services for a period of up

to 90 days from the date of the primary care provider's notice of termination from a carrier's provider panel, except when a provider is terminated for cause.

2. Notifying a provider at least 90 days prior to the date of the termination of the provider *or implementation of a policy that restricts enrollee access to the provider's services,* except when a provider is terminated for cause.

3. Providing reasonable notice to primary care providers in the carrier's provider panel of the termination of a specialty referral services provider *or implementation of a policy that restricts enrollee access to the specialty referral services provider*.

4. Notifying the purchaser of the health benefit plan, whether such purchaser is an individual or an employer providing a health benefit plan, in whole or in part, to its employees and enrollees of the health benefit plan of:

a. A description of all types of payment arrangements that the carrier uses to compensate providers for health care services rendered to enrollees, including, but not limited to, withholds, bonus payments, capitation and fee-for-service discounts; ~~and~~

b. The terms of the plan in clear and understandable language that reasonably informs the purchaser of the practical application of such terms in the operation of the plan*; and*

c. Any change in policy that restricts enrollee access to a contracted provider.

D. Whenever a provider voluntarily terminates his contract with a carrier to provide health care services to the carrier's enrollees under a health benefit plan, he shall furnish reasonable notice of such termination to his patients who are enrollees under such plan.

E. A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of gender, race, age, sexual orientation, gender identity, religion or national origin.

F. 1. For a period of at least 90 days from the date of the notice of a provider's termination from the carrier's provider panel, except when a provider is terminated for cause, the provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees who:

a. Were in an active course of treatment from the provider prior to the notice of termination; and

b. Request to continue receiving health care services from the provider.

2. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who has entered the second trimester of pregnancy at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the enrollee's option, continue through the provision of postpartum care directly related to the delivery.

3. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who is determined to be terminally ill (as defined under § 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the enrollee's option, continue for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

4. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

G. 1. A carrier shall provide to a purchaser upon enrollment and make available to existing enrollees at least once a year a list of members in its provider panel, which list shall also indicate those providers who are not currently accepting new patients. Such list may be made available in a form other than a printed document, provided the purchaser or existing enrollee is given the means to request and receive a printed copy of such list.

2. The information provided under subdivision 1 shall be updated at least once a year if in paper form, and monthly if in electronic form.

H. No contract between a carrier and a provider may require that the provider indemnify the carrier for the carrier's negligence, willful misconduct, or breach of contract, if any.

I. No contract between a carrier and a provider shall require a provider, as a condition of participation on the panel, to waive any right to seek legal redress against the carrier.

J. No contract between a carrier and a provider shall prohibit, impede or interfere in the discussion of medical treatment options between a patient and a provider.

K. A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

L. Any carrier requiring preauthorization for medical treatment shall have personnel available to provide such preauthorization at all times when such preauthorization is required.

M. Carriers shall provide to their group policyholders written notice of any benefit reductions during the contract period at least 60 days before such benefit reductions become effective. Group policyholders shall, in turn, provide to their enrollees written notice of any benefit reductions during the contract period at least 30 days before such benefit reductions become effective. Such notice shall be provided to

the group policyholder as a separate and distinct notification, and may not be combined with any other notification or marketing materials.

N. No contract between a provider and a carrier shall include provisions that require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions.

O. If a provider panel contract between a provider and a carrier, or other entity that provides hospital, physician or other health care services to a carrier, includes provisions that require a provider, as a condition of participating in one of the carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that carrier or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more such other provider panels at the time the contract is executed. If a provider contracts with a carrier or other entity that subsequently contracts with one or more unaffiliated carriers to include such provider in the provider panels of such unaffiliated carriers, and which permits an unaffiliated carrier to impose participation terms with respect to such provider that differ materially in reimbursement rates or in managed care procedures, such as conducting economic profiling or requiring a patient to obtain primary care physician referral to a specialist, from the terms agreed to by the provider in the original contract, the provider panel contract shall contain a provision permitting the provider to refuse participation with any such unaffiliated carrier. Utilization review pursuant to Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not constitute a materially different managed care procedure. This subsection shall apply to provider panels utilized by health maintenance organizations and preferred provider organizations. For purposes of this subsection, "preferred provider organization" means a carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209. The status of a physician as a member of or as being eligible for other existing or new provider panels shall not be adversely affected by the exercise of such right to refuse participation. This subsection shall not apply to the Medallion II and children's health insurance plan administered by or pursuant to contract with the Department of Medical Assistance Services.

P. A carrier that rents or leases its provider panel to unaffiliated carriers shall make available, upon request, to its providers a list of unaffiliated carriers that rent or lease its provider panel. Such list if available in electronic format shall be updated monthly. The provider shall be given the means to request and receive a printed copy of such list.

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

R. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on or after July 1, 1996. However, the 90-day period referred to in subdivisions C 1 b and C 2 of this section, the requirements set forth in subdivisions F 2 and F 3, and the requirements set forth in subsections L, M, and N shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1999, the requirements set forth in subsection O shall apply to contracts between carriers and providers that are entered into, reissued, extended or renewed on or after July 1, 2001, and the requirements set forth in subsection P shall be effective on and after January 1, 2007.

§ 38.2-3407.14. Notice of premium or deductible increases.

A. Each (i) insurer issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, shall provide in conjunction with the proposed renewal of coverage under any such policies, contracts, or plans, prior written notice of intent to increase by more than ~~35~~ *15* percent the annual premium charged for coverage thereunder.

B. Effective with policy, contract, or plan year renewals beginning on or after January 1, 2015, each health carrier providing individual health insurance coverage shall provide in conjunction with the proposed renewal of individual health insurance coverage prior written notice of intent to increase the annual premium charge for coverage or any deductible required thereunder. As used in this section, "deductible" means the annual dollar amount of covered items or services that the insured, subscriber, or enrollee is obligated to pay before benefits are payable under the health benefit plan.

C. Notice required by this section shall be provided in writing at least 60 days prior to the proposed renewal of coverage under any such policy, contract, or plan described in subsection A and effective with policy, contract, or plan year renewals beginning on or after January 1, 2015, at least 75 days prior to the proposed renewal of individual health insurance coverage described in subsection B. In either case, notice shall be provided to the policyholder, contract holder, or subscriber, or to the designated consultant or other agent of the group policyholder, contract holder, or subscriber if requested in writing by the group policyholder, contract holder, or subscriber, as appropriate.

D. The time frames specified in subsection C for the provision of notices may be adjusted by the Commission's Bureau of Insurance to account for delays in product or rate approval by the Bureau of

Insurance that result from filing requirements established by the United States Department of Health and Human Services.