COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
October 17, 1994

ADMINISTRATIVE LETTER 1994-8

TO: **All Insurers, Health Services Plans, and Health Maintenance Organizations licensed to write Accident and Sickness Insurance in Virginia**

RE: **Freedom of choice requirements - Pharmacies and Ancillary Service Providers**

Chapter No. 963 of the 1994 Acts of the General Assembly of Virginia (1994 House Bill 840), took effect on July 1, 1994. The bill created six (6) new statutes, designated by the Virginia Code Commission as Sections 38.2-3407.7, 38.2-3407.8, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1, and 38.2-4312.2 of the Code of Virginia, as amended. These new requirements, which are imposed upon insurers issuing "preferred provider" policies or contracts and upon health maintenance organizations, relate to coverage for services rendered and products furnished by out-of-network pharmacies and ancillary service providers.

It has come to my attention that several issues have arisen regarding the interpretation of certain provisions of this legislation. The following is an explanation of how the Bureau of Insurance intends to administer certain requirements found in the new statutes listed above.

DEFINITION OF "ANCILLARY SERVICES"

The term "ancillary services" is defined in §§ 38.2-3407.8, 38.2-4209.2, and 38.2-4312.2 as: *"those services required to support, facilitate or otherwise enhance medical care and treatment."* These statutes also provide that: *"the furnishing of durable medical equipment required for therapeutic purposes or life support"* is an example of ancillary services. It is the Bureau's position that the statutory definition of ancillary services is an extremely broad one, and cannot reasonably be construed as limited to the provision of durable medical equipment. Unless and until the statutory definition is made more restrictive, then, it is our position that any person or class of persons that provides services that *"support, facilitate or otherwise enhance medical care and treatment"* meets the definition of an "ancillary service provider."

Each of the statutes cited above contains the following language:

> The [State Corporation] Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

Therefore, the Bureau does not have the authority to intervene in disagreements among parties affected by these new requirements. Questions of interpretation concerning whether or not a provider is providing "ancillary services" will have to be resolved in forums other than the State Corporation Commission.

CONTRACT PROVISIONS

All six statutes cited above contain specific language prohibiting the imposition of:

> ...any copayment, fee, or condition that is not equally imposed upon all individuals in the same benefit category, class, or copayment level, whether or not such benefits are furnished by [pharmacists or ancillary service providers] who are [non preferred or nonparticipating] providers. (emphasis added)

It is our position that each of these provisions prohibits an insurer or health maintenance organization from amending its contracts to provide that claimants obtaining services from out-of-network pharmacies or ancillary service providers must pay for the services and then seek reimbursement from the insurer or health maintenance organization, unless this same condition is imposed upon claimants utilizing the services of in-network pharmacists or ancillary service providers. Additionally, if information regarding coverage is available to in-network providers, such information must also be made available to out-of-network providers in the same or substantially similar manner.

All six statutes cited above also contain the following provision:

> This right of selection extends to and includes [pharmacies or ancillary service providers] that are [non preferred or nonparticipating] providers and that agree to accept reimbursement for their services at rates applicable to [pharmacies or ancillary service providers] that are [preferred or participating] providers. (emphasis added)

It is our position that affected insurers and health maintenance organizations must maintain records of written agreements with out-of-network pharmacies and ancillary service providers that have agreed to accept the rates applicable to preferred or participating providers. Any reference by the insurer or health maintenance organization to the possibility of a pharmacy or ancillary service provider billing the insured for the difference between the network rates and those charged must clearly state that the insured can verify in advance of a purchase that the provider in question has entered into an agreement to accept the network rate as payment in full to avoid additional charges. This verification must be provided by the insurer or health maintenance organization providing coverage.

This letter serves as notice of our intention to withdraw approval, pursuant to § 38.2-316 of the Code of Virginia, as amended, of any forms of which we become aware that do not comply in all respects with the provisions of §§ 38.2-3407.7, 38.2-3407.8, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1, and 38.2-4312.2 of the Code of Virginia, as amended. **Insurers and health maintenance organizations are instructed to review their forms immediately and file amendments, within 45 days of the date of this letter, for the purpose of bringing any non-complying forms into compliance with the statutes discussed herein.** Subsequently, any forms brought to our attention that do not comply will have their approval withdrawn, and the Bureau will consider initiation of any other disciplinary proceedings deemed

appropriate in the circumstances. **It should be noted that the wording of each of the statutes listed above is sufficiently broad so as to apply to in force contracts as well as newly issued contracts.**

Insurers and health maintenance organizations are also hereby instructed to take appropriate steps to expedite communication and agreement with non-network providers wishing to enter into agreements to accept reimbursement at network rates.

Any questions regarding the administration of these requirements should be directed to the attention of Althelia P. Battle, Senior Insurance Market Examiner, or Robert R. Knapp, Senior Insurance Market Examiner, Life and Health Forms and Rates Section, at the above address. The telephone number for the Forms and Rates Section is (804) 371-9110.

Sincerely yours,

Steven T. Foster
Commissioner of Insurance

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