

2026 SESSION

INTRODUCED

26103575D

HOUSE BILL NO. 618

Offered January 14, 2026

Prefiled January 13, 2026

A BILL to amend and reenact §§ 2.2-2818, 38.2-3445.02, 38.2-3462, 38.2-4214, 38.2-4319, and 38.2-5904 of the Code of Virginia; to amend the Code of Virginia by adding in Article 2 of Chapter 34 of Title 38.2 a section numbered 38.2-3419.2; and to repeal §§ 38.2-3419.1, 38.2-3445.2, and 38.2-5601 of the Code of Virginia, relating to health insurance; reporting requirements.

Patron—Shin

Committee Referral Pending

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 38.2-3445.02, 38.2-3462, 38.2-4214, 38.2-4319, and 38.2-5904 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 2 of Chapter 34 of Title 38.2 a section numbered 38.2-3419.2 as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical, and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The same plan shall be offered to all part-time state employees, but the total cost shall be paid by such part-time employees. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. Except for part-time employees, the Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee, including a part-time employee, may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over and may be limited to a benefit of \$50 per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization provider; (ii) performed by a registered technologist; (iii) interpreted by a qualified radiologist; and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for postpartum services providing inpatient care and a home visit or visits that shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

3. Include an appeals process for resolution of complaints that shall provide reasonable procedures for the resolution of such complaints and shall be published and disseminated to all covered state employees. The

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59 appeals process shall be compliant with federal rules and regulations governing nonfederal, self-insured
60 governmental health plans. The appeals process shall include a separate expedited emergency appeals
61 procedure that shall provide resolution within time frames established by federal law. For appeals involving
62 adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more independent
63 review organizations to review such decisions. Independent review organizations are entities that conduct
64 independent external review of adverse benefit determinations. The Department shall adopt regulations to
65 assure that the independent review organization conducting the reviews has adequate standards, credentials
66 and experience for such review. The independent review organization shall examine the final denial of claims
67 to determine whether the decision is objective, clinically valid, and compatible with established principles of
68 health care. The decision of the independent review organization shall (i) be in writing, (ii) contain findings
69 of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if
70 consistent with law and policy.

71 Prior to assigning an appeal to an independent review organization, the Department shall verify that the
72 independent review organization conducting the review of a denial of claims has no relationship or
73 association with (i) the covered person or the covered person's authorized representative; (ii) the treating
74 health care provider, or any of its employees or affiliates; (iii) the medical care facility at which the covered
75 service would be provided, or any of its employees or affiliates; or (iv) the development or manufacture of
76 the drug, device, procedure, or other therapy that is the subject of the final denial of a claim. The independent
77 review organization shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association
78 of health plans, or a professional association of health care providers. There shall be no liability on the part of
79 and no cause of action shall arise against any officer or employee of an independent review organization for
80 any actions taken or not taken or statements made by such officer or employee in good faith in the
81 performance of his powers and duties.

82 4. Include coverage for early intervention services. For purposes of this section, "early intervention
83 services" means medically necessary speech and language therapy, occupational therapy, physical therapy
84 and assistive technology services and devices for dependents from birth to age three who are certified by the
85 Department of Behavioral Health and Developmental Services as eligible for services under Part H of the
86 Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention
87 services for the population certified by the Department of Behavioral Health and Developmental Services
88 shall mean those services designed to help an individual attain or retain the capability to function age-
89 appropriately within his environment, and shall include services that enhance functional ability without
90 effecting a cure.

91 For persons previously covered under the plan, there shall be no denial of coverage due to the existence of
92 a preexisting condition. The cost of early intervention services shall not be applied to any contractual
93 provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the
94 insured's lifetime.

95 5. Include coverage for prescription drugs and devices approved by the United States Food and Drug
96 Administration for use as contraceptives.

97 6. Not deny coverage for any drug approved by the United States Food and Drug Administration for use
98 in the treatment of cancer on the basis that the drug has not been approved by the United States Food and
99 Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if
100 the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the
101 standard reference compendia.

102 7. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been
103 approved by the United States Food and Drug Administration for at least one indication and the drug is
104 recognized for treatment of the covered indication in one of the standard reference compendia or in
105 substantially accepted peer-reviewed medical literature.

106 8. Include coverage for equipment, supplies, and outpatient self-management training and education,
107 including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes,
108 gestational diabetes, and noninsulin-using diabetes if prescribed by a health care professional legally
109 authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes
110 outpatient self-management training and education shall be provided by a certified, registered, or licensed
111 health care professional.

112 9. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast
113 surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for
114 breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the
115 two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to
116 preexisting conditions.

117 10. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual
118 testing performed by any FDA-approved gynecologic cytology screening technologies.

119 11. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient
120 following a radical or modified radical mastectomy and 24 hours of inpatient care following a total

121 mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in
 122 this subdivision shall be construed as requiring the provision of inpatient coverage where the attending
 123 physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

124 12. Include coverage (i) to persons age 50 and over and (ii) to persons age 40 and over who are at high
 125 risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society,
 126 for one prostate-specific antigen test in a 12-month period and digital rectal examinations.

127 13. Permit any individual covered under the plan direct access to the health care services of a participating
 128 specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The
 129 plan shall have a procedure by which an individual who has an ongoing special condition may, after
 130 consultation with the primary care physician, receive a referral to a specialist for such condition who shall be
 131 responsible for and capable of providing and coordinating the individual's primary and specialty care related
 132 to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by
 133 such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision,
 134 "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii)
 135 requires specialized medical care over a prolonged period of time. Within the treatment period authorized by
 136 the referral, such specialist shall be permitted to treat the individual without a further referral from the
 137 individual's primary care provider and may authorize such referrals, procedures, tests, and other medical
 138 services related to the initial referral as the individual's primary care provider would otherwise be permitted
 139 to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special
 140 condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the
 141 treatment of the special condition. If the primary care provider, in consultation with the plan and the
 142 specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a
 143 referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating
 144 specialist to provide written notification to the covered individual's primary care physician of any visit to
 145 such specialist. Such notification may include a description of the health care services rendered at the time of
 146 the visit.

147 14. Include provisions allowing employees to continue receiving health care services for a period of up to
 148 90 days from the date of the primary care physician's notice of termination from any of the plan's provider
 149 panels. The plan shall notify any provider at least 90 days prior to the date of termination of the provider,
 150 except when the provider is terminated for cause.

151 For a period of at least 90 days from the date of the notice of a provider's termination from any of the
 152 plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the
 153 plan to render health care services to any of the covered employees who (i) were in an active course of
 154 treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care
 155 services from the provider.

156 Notwithstanding the provisions of this subdivision, any provider shall be permitted by the plan to continue
 157 rendering health services to any covered employee who has entered the second trimester of pregnancy at the
 158 time of the provider's termination of participation, except when a provider is terminated for cause. Such
 159 treatment shall, at the covered employee's option, continue through the provision of postpartum care directly
 160 related to the delivery.

161 Notwithstanding the provisions of this subdivision, any provider shall be permitted to continue rendering
 162 health services to any covered employee who is determined to be terminally ill (as defined under §
 163 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, except
 164 when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for
 165 the remainder of the employee's life for care directly related to the treatment of the terminal illness.

166 A provider who continues to render health care services pursuant to this subdivision shall be reimbursed
 167 in accordance with the carrier's agreement with such provider existing immediately before the provider's
 168 termination of participation.

169 15. Include coverage for patient costs incurred during participation in clinical trials for treatment studies
 170 on cancer, including ovarian cancer trials.

171 The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on
 172 cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical
 173 procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments, and
 174 coinsurance factors that are no less favorable than for physical illness generally.

175 For purposes of this subdivision:

176 "Cooperative group" means a formal network of facilities that collaborate on research projects and have
 177 an established NIH-approved peer review program operating within the group. "Cooperative group" includes
 178 (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute
 179 Community Clinical Oncology Program.

180 "FDA" means the Federal Food and Drug Administration.

181 "Multiple project assurance contract" means a contract between an institution and the federal Department

182 of Health and Human Services that defines the relationship of the institution to the federal Department of
183 Health and Human Services and sets out the responsibilities of the institution and the procedures that will be
184 used by the institution to protect human subjects.

185 "NCI" means the National Cancer Institute.

186 "NIH" means the National Institutes of Health.

187 "Patient" means a person covered under the plan established pursuant to this section.

188 "Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the
189 treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not include (i) the
190 cost of nonhealth care services that a patient may be required to receive as a result of the treatment being
191 provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the
192 clinical trial, or (iii) the cost of the investigational drug or device.

193 Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided
194 if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may,
195 however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

196 The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

197 a. The National Cancer Institute;

198 b. An NCI cooperative group or an NCI center;

199 c. The FDA in the form of an investigational new drug application;

200 d. The federal Department of Veterans Affairs; or

201 e. An institutional review board of an institution in the Commonwealth that has a multiple project
202 assurance contract approved by the Office of Protection from Research Risks of the NCI.

203 The facility and personnel providing the treatment shall be capable of doing so by virtue of their
204 experience, training, and expertise.

205 Coverage under this subdivision shall apply only if:

206 (1) There is no clearly superior, noninvestigational treatment alternative;

207 (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at
208 least as effective as the noninvestigational alternative; and

209 (3) The patient and the physician or health care provider who provides services to the patient under the
210 plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures
211 established by the plan.

212 16. Include coverage providing a minimum stay in the hospital of not less than 23 hours for a covered
213 employee following a laparoscopy-assisted vaginal hysterectomy and 48 hours for a covered employee
214 following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines.
215 Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when
216 the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is
217 appropriate.

218 17. Include coverage for biologically based mental illness.

219 For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous condition
220 caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially
221 limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental
222 illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major
223 depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder,
224 autism, and drug and alcoholism addiction.

225 Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for
226 any other illness, condition, or disorder for purposes of determining deductibles, benefit year or lifetime
227 durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and
228 coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

229 Nothing shall preclude the undertaking of usual and customary procedures to determine the
230 appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this
231 option, provided that all such appropriateness and medical necessity determinations are made in the same
232 manner as those determinations made for the treatment of any other illness, condition, or disorder covered by
233 such policy or contract.

234 18. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery
235 or such other methods as may be recognized by the National Institutes of Health as effective for the long-term
236 reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments,
237 and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for
238 morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National
239 Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100
240 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan
241 Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared
242 with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep

243 apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used
 244 herein, "BMI" equals weight in kilograms divided by height in meters squared.

245 19. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult
 246 blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in
 247 accordance with the most recently published recommendations established by the American College of
 248 Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and
 249 frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be
 250 more restrictive than or separate from coverage provided for any other illness, condition, or disorder for
 251 purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar
 252 limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum
 253 for deductibles and copayments and coinsurance factors.

254 20. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or
 255 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee
 256 provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth
 257 in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such
 258 corrective information as may be required to electronically process a prescription claim.

259 21. Include coverage for infant hearing screenings and all necessary audiological examinations provided
 260 pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration,
 261 and as recommended by the national Joint Committee on Infant Hearing in its most current position statement
 262 addressing early hearing detection and intervention programs. Such coverage shall include follow-up
 263 audiological examinations as recommended by a physician, a physician assistant, an advanced practice
 264 registered nurse, or an audiologist and performed by a licensed audiologist to confirm the existence or
 265 absence of hearing loss.

266 22. Notwithstanding any provision of this section to the contrary, every plan established in accordance
 267 with this section shall comply with the provisions of § 2.2-2818.2.

268 C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such
 269 funds as shall be appropriated by law. Appropriations, premiums, and other payments shall be deposited in
 270 the employee health insurance fund, from which payments for claims, premiums, cost containment programs,
 271 and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund
 272 shall be deemed separate and independent trust funds, shall be segregated from all other funds of the
 273 Commonwealth, and shall be invested and administered solely in the interests of the employees and their
 274 beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or
 275 authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and
 276 administrative expenses, including but not limited to legislative oversight of the health insurance fund.

277 D. For the purposes of this section:

278 "Peer-reviewed medical literature" means a scientific study published only after having been critically
 279 reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has
 280 been determined by the International Committee of Medical Journal Editors to have met the Uniform
 281 Requirements for Manuscripts submitted to biomedical journals. "Peer-reviewed medical literature" does not
 282 include publications or supplements to publications that are sponsored to a significant extent by a
 283 pharmaceutical manufacturing company or health carrier.

284 "Standard reference compendia" means:

- 285 1. American Hospital Formulary Service Drug Information;
- 286 2. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
- 287 3. Elsevier Gold Standard's Clinical Pharmacology.

288 "State employee" means state employee as defined in § 51.1-124.3; employee as defined in § 51.1-201;
 289 the Governor, Lieutenant Governor and Attorney General; judge as defined in § 51.1-301 and judges, clerks,
 290 and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and
 291 district courts of the Commonwealth; interns and residents employed by the School of Medicine and Hospital
 292 of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth
 293 University Health System Authority as provided in § 23.1-2415; and employees of the Virginia Alcoholic
 294 Beverage Control Authority as provided in § 4.1-101.05.

295 E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as
 296 an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all
 297 or any portion of the cost thereof.

298 F. Any self-insured group health insurance plan established by the Department of Human Resource
 299 Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis
 300 of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan
 301 criteria established by the Department.

302 G. The plan shall include, in each planning district, at least two health coverage options, each sponsored
 303 by unrelated entities. No later than July 1, 2006, one of the health coverage options to be available in each
 304 planning district shall be a high deductible health plan that would qualify for a health savings account

305 pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

306 In each planning district that does not have an available health coverage alternative, the Department shall
307 voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide
308 coverage under the plan.

309 This subsection shall not apply to any state agency authorized by the Department to establish and
310 administer its own health insurance coverage plan separate from the plan established by the Department.

311 H. Any self-insured group health insurance plan established by the Department of Human Resource
312 Management that includes coverage for prescription drugs on an outpatient basis may apply a formulary to
313 the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually,
314 and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics
315 committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and
316 (iii) other health care providers.

317 If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to
318 obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a
319 specific, medically necessary nonformulary prescription drug if, after reasonable investigation and
320 consultation with the prescriber, the formulary drug is determined to be an inappropriate therapy for the
321 medical condition of the person. The plan shall act on such requests within one business day of receipt of the
322 request.

323 Any plan established in accordance with this section shall be authorized to provide for the selection of a
324 single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the
325 covered person's address by mail, common carrier, or delivery service. As used in this subsection, "mail order
326 pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary
327 business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or
328 device to a patient primarily by mail, common carrier, or delivery service.

329 I. Any plan established in accordance with this section requiring preauthorization prior to rendering
330 medical treatment shall have personnel available to provide authorization at all times when such
331 preauthorization is required.

332 J. Any plan established in accordance with this section shall provide to all covered employees written
333 notice of any benefit reductions during the contract period at least 30 days before such reductions become
334 effective.

335 K. No contract between a provider and any plan established in accordance with this section shall include
336 provisions that require a health care provider or health care provider group to deny covered services that such
337 provider or group knows to be medically necessary and appropriate that are provided with respect to a
338 covered employee with similar medical conditions.

339 L. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect
340 the interests of covered employees under any state employee's health plan.

341 The Ombudsman shall:

342 1. Assist covered employees in understanding their rights and the processes available to them according to
343 their state health plan.

344 2. Answer inquiries from covered employees by telephone and electronic mail.

345 3. Provide to covered employees information concerning the state health plans.

346 4. Develop information on the types of health plans available, including benefits and complaint
347 procedures and appeals.

348 5. Make available, either separately or through an existing Internet web site utilized by the Department of
349 Human Resource Management, information as set forth in subdivision 4 and such additional information as
350 he deems appropriate.

351 6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the
352 disposition of each such matter.

353 7. Upon request, assist covered employees in using the procedures and processes available to them from
354 their health plan, including all appeal procedures. Such assistance may require the review of health care
355 records of a covered employee, which shall be done only in accordance with the federal Health Insurance
356 Portability and Accountability Act privacy rules. The confidentiality of any such medical records shall be
357 maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

358 8. Ensure that covered employees have access to the services provided by the Ombudsman and that the
359 covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

360 9. Report annually on his activities to the standing committees of the General Assembly having
361 jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each
362 year.

363 M. The plan established in accordance with this section shall not refuse to accept or make reimbursement
364 pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

365 For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage

366 reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until
 367 the covered employee notifies the plan in writing of the assignment.

368 N. Beginning July 1, 2006, any plan established pursuant to this section shall provide for an identification
 369 number, which shall be assigned to the covered employee and shall not be the same as the employee's social
 370 security number.

371 O. Any group health insurance plan established by the Department of Human Resource Management that
 372 contains a coordination of benefits provision shall provide written notification to any eligible employee as a
 373 prominent part of its enrollment materials that if such eligible employee is covered under another group
 374 accident and sickness insurance policy, group accident and sickness subscription contract, or group health
 375 care plan for health care services, that insurance policy, subscription contract, or health care plan may have
 376 primary responsibility for the covered expenses of other family members enrolled with the eligible employee.
 377 Such written notification shall describe generally the conditions upon which the other coverage would be
 378 primary for dependent children enrolled under the eligible employee's coverage and the method by which the
 379 eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered
 380 expenses of each family member.

381 P. Any plan established by the Department of Human Resource Management pursuant to this section shall
 382 provide that coverage under such plan for family members enrolled under a participating state employee's
 383 coverage shall continue for a period of at least 30 days following the death of such state employee.

384 Q. The plan established in accordance with this section that follows a policy of sending its payment to the
 385 covered employee or covered family member for a claim for services received from a nonparticipating
 386 physician or osteopath shall (i) include language in the member handbook that notifies the covered employee
 387 of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include
 388 this language with any such payment sent to the covered employee or covered family member, and (iii)
 389 include the name and any last known address of the nonparticipating provider on the explanation of benefits
 390 statement.

391 R. The plan established by the Department of Human Resource Management pursuant to this section shall
 392 provide that coverage under such plan for an incapacitated child enrolled under a participating state
 393 employee's coverage shall be valid without regard to whether such child lives with the covered employee as a
 394 member of the employee's household so long as the child is dependent upon the employee for more than half
 395 of the child's financial support and the child is receiving residential support services.

396 For purposes of this subsection, "incapacitated child" means an adult child who is incapacitated due to a
 397 physical or mental health condition that existed prior to the termination of coverage due to such child
 398 attaining the limiting age under the plan for eligible children dependents.

399 S. The Department of Human Resource Management shall report annually, by November 30 of each year,
 400 on cost and utilization information for each of the mandated benefits set forth in subsection B, including any
 401 mandated benefit made applicable, pursuant to subdivision B 22, to any plan established pursuant to this
 402 section. ~~The report shall be in the same detail and form as required of reports submitted pursuant to~~
 403 ~~§ 38.2-3419.1, with such additional information as is required to determine the financial impact, including the~~
 404 ~~costs and benefits, of the particular mandated benefit.~~

405 **§ 38.2-3419.2. Inventory of mandated benefits and providers.**

406 *The Commission shall maintain an inventory of the mandated benefits and providers set forth in this
 407 article and such other information as the Commission may deem necessary. The Commission shall make the
 408 inventory available to the public by posting it on the Commission's website and by any other means the
 409 Commission finds appropriate.*

410 **§ 38.2-3445.02. Arbitration; provider termination and reinstatement; reporting requirements.**

411 A. If good faith negotiation, as described in § 38.2-3445.01, does not result in resolution of the dispute,
 412 and the carrier or the out-of-network provider chooses to pursue further action to resolve the dispute, the
 413 carrier or out-of-network provider shall initiate arbitration to determine a commercially reasonable payment
 414 amount. To initiate arbitration, the carrier or provider shall provide written notification to the Commission
 415 and the noninitiating party no later than 10 calendar days following completion of the period of good faith
 416 negotiation provided in § 38.2-3445.01. Such notification shall state the initiating party's final offer. No later
 417 than 30 calendar days following receipt of the notification, the noninitiating party shall provide its final offer
 418 to the initiating party. The parties may reach an agreement on reimbursement during this time and before the
 419 arbitration proceeding.

420 B. The parties shall be permitted to bundle claims for arbitration. Multiple claims may be addressed in a
 421 single arbitration proceeding if the claims at issue (i) involve identical carrier and provider parties, (ii)
 422 involve claims with the same or related current procedural terminology codes relevant to a particular
 423 procedure, and (iii) occur within a period of two months of one another.

424 C. Within seven calendar days of receipt of notification from the initiating party, the Commission shall
 425 provide the parties with a list of approved arbitrators or entities that provide arbitrations. The arbitrators on
 426 the list shall not have a conflict of interest with the parties and shall be trained and have experience and be
 427 selected by the Commission as set out in the standards established by the Commission through regulation.

428 The parties may agree on an arbitrator from the list provided by the Commission. If the parties do not agree
429 on an arbitrator, they shall notify the Commission, and the Commission shall provide the parties with the
430 names of five arbitrators from the list. Each party may veto up to two of the five named arbitrators. If one
431 arbitrator remains, that arbitrator shall be the chosen arbitrator. If more than one arbitrator remains, the
432 Commission shall choose the arbitrator from the remaining arbitrators. The parties and the Commission shall
433 complete this process within 20 calendar days of receipt of the original list from the Commission.

434 D. No later than 30 days after final selection of the arbitrator pursuant to subsection C, each party shall
435 provide written submissions in support of its position to the arbitrator. The initiating party shall include in its
436 written submission the evidence and methodology for asserting that the amount proposed to be paid is or is
437 not commercially reasonable. A party that fails to make timely written submissions under this subsection
438 without good cause shown shall be considered to be in default, and the arbitrator shall require the defaulting
439 party to pay the final offer of the nondefaulting party and may require the defaulting party to pay the
440 arbitrator's fixed fee. Written submissions required by this subsection may be submitted electronically.

441 E. No later than 30 calendar days after the receipt of the parties' written submissions, the arbitrator shall
442 (i) issue a written decision requiring payment of the final offer amount of either the initiating or noninitiating
443 party, (ii) notify the parties of the decision, and (iii) provide the decision and the information described in
444 subsection I to the Commission.

445 F. In reviewing the submissions of the parties and making a decision requiring payment of the final offer
446 amount of either the initiating or noninitiating party, the arbitrator shall consider the following factors:

447 1. The evidence and methodology submitted by the parties to assert that their final offer amount is
448 reasonable; and

449 2. Patient characteristics and the circumstances and complexity of the case, including time and place of
450 service and type of facility, that are not already reflected in the provider's billing code for the service.

451 The arbitrator may also consider other information that a party believes is relevant to the required factors
452 included in this subsection or other information requested by the arbitrator and information provided by the
453 parties that is relevant to such request, including data sets developed pursuant to § 38.2-3445.03. The
454 arbitrator shall not require extrinsic evidence of authenticity for admitting such data sets.

455 G. The Commission shall establish a schedule of fixed fees for the costs of arbitration. Except as provided
456 in subsection D, such fees shall be divided equally among the parties to the arbitration. The enrollee shall not
457 be liable for any of the costs of arbitration and shall not be required to participate in the arbitration process as
458 a witness or otherwise.

459 H. Within 10 business days of a party notifying the Commission and the noninitiating party of intent to
460 initiate arbitrations, both parties shall agree to and execute a nondisclosure agreement. The nondisclosure
461 agreement shall not preclude the arbitrator from submitting the arbitrator's decision to the Commission or
462 impede the Commission's duty to prepare the annual report required by subsection I.

463 *I. Any health carrier providing individual or group health insurance coverage shall report to the Bureau
464 no later than September 1 of each year the number of health care providers in the health carrier's network of
465 emergency services providers and surgical or ancillary providers whose participation in the network was
466 terminated by either the health carrier or the health care provider in the previous year and, if applicable,
467 whether participation was subsequently reinstated within the same year. For any terminated health care
468 provider identified in such report, the health carrier shall include (i) a description of the health care
469 provider's or health carrier's stated reason for terminating participation and (ii) a description of the nature
470 and extent of differences in payment levels for emergency services and surgical or ancillary services prior to
471 termination and after reinstatement, if applicable, including a determination of whether such payment levels
472 after reinstatement were higher or lower than those applied prior to termination.*

473 J. The Commission shall prepare an annual report summarizing the dispute resolution information
474 provided by arbitrators, including information related to the matters decided through arbitration as well as the
475 following information for provided by health carriers pursuant to subsection I. For each dispute resolved
476 through arbitration, the report shall include the name of the carrier, the name of the health care provider, the
477 health care provider's employer or the business entity in which the provider has an ownership interest name of
478 the filing party, the health care facility where the services were provided rendered, and the type of health care
479 services at issue, and in which party's favor the dispute was resolved. The report shall also include (i)
480 the number and type of claims resolved by arbitration; (ii) aggregate information on the disposition of such
481 arbitrations, including in which party's favor the dispute was resolved; (iii) aggregate information on the
482 variation between the initial payment and final settlement amounts; (iv) the number of health care providers
483 in the health carrier's network of emergency services providers and surgical or ancillary services providers
484 whose participation in the network was terminated by the health carrier or the health care provider in the
485 previous year and whose participation was subsequently reinstated in the same year; and (v) a summary of
486 the nature and extent of differences in payment levels prior to termination and after reinstatement, if
487 applicable, including a determination of whether such payment levels after reinstatement were higher or
488 lower than those applied prior to termination. The Commission shall post the report on the Bureau's website
489 and submit it to the Chairs of the House Committee on Labor and Commerce and Committee on

490 Appropriations and the Senate Committee on Commerce and Labor and Committee on Finance and
 491 Appropriations annually by ~~July~~ December 1. The provisions of this subsection shall expire on ~~July 1, 2025~~
 492 December 1, 2030.

493 J. K. The Commission shall establish an appeals process for a party to appeal to the Commission an
 494 arbitrator's decision on the grounds that (i) the decision was substantially influenced by corruption, fraud, or
 495 other undue means; (ii) there was evident partiality, corruption, or misconduct prejudicing the rights of any
 496 party; (iii) the arbitrator exceeded his powers; or (iv) the arbitrator conducted the proceeding contrary to the
 497 provisions of this section and Commission regulations, in such a way as to materially prejudice the rights of
 498 the party.

499 K. L. The provisions of the Uniform Arbitration Act, Article 2 (§ 8.01-581.01 et seq.) of Chapter 21 of
 500 Title 8.01, shall not apply to arbitration proceedings initiated pursuant to this section.

501 **§ 38.2-3462. Comparable Health Care Service Incentive Program.**

502 A. Beginning with health benefit plans offered or renewed on or after January 1, 2021, each health carrier
 503 offering a health benefit plan in the Commonwealth shall develop and implement a program that provides
 504 incentives for covered persons in its health benefit plan who elect to receive a comparable health care service
 505 that is covered by the health benefit plan from health care providers that are paid less than the average in-
 506 network allowed amount paid or payable by that health carrier to network providers for that comparable
 507 health care service. A health carrier may base the average paid to a network provider on what that health
 508 carrier pays to providers in the network applicable to the covered person's specific health benefit plan, or
 509 across all of its health benefit plans offered in the Commonwealth.

510 B. Incentives may include, but are not limited to, cash payments, gift cards, or credits or reductions of
 511 premiums, copayments, or deductibles. Health carriers may let covered persons decide which method they
 512 prefer to receive the incentive.

513 C. The incentive program shall provide covered persons with an incentive for each service or category of
 514 comparable health care service resulting from comparison shopping by covered persons. A health carrier is
 515 not required to provide a payment or credit to a covered person when the health carrier's saved cost is \$25 or
 516 less.

517 D. A health carrier shall determine the allowed amount paid or payable by that health carrier to network
 518 providers for that comparable health care service on the basis of the average allowed amount for the
 519 procedure or service under the covered person's health benefit plan. Such determination shall be made on the
 520 basis of the average of the allowed amounts using data collected over a reasonable period not to exceed one
 521 year. A health carrier may determine an alternate methodology for calculating the average allowed amount if
 522 approved by the Commission. A health carrier shall, at minimum, inform covered persons of their eligibility
 523 for an incentive payment and the process to request the average allowed amount for a procedure or service on
 524 the health carrier's website and in health benefit plan materials.

525 E. Eligibility for an incentive payment may require a covered person to demonstrate, through reasonable
 526 documentation such as a quote from the health care provider, that the covered person shopped prior to
 527 receiving care from the health care provider who charges less for the comparable health care service than the
 528 average allowed amount paid or payable by that health carrier. Health carriers shall provide additional
 529 mechanisms for the covered person to satisfy this requirement by utilizing the health carrier's cost
 530 transparency website or toll-free number, established under this article.

531 F. Each health carrier shall make the program available as a component of all small group health benefit
 532 plans offered by the health carrier in the Commonwealth. Annually at enrollment or renewal, each health
 533 carrier shall provide to any covered person who is enrolled in a small group health benefit plan eligible for
 534 the program (i) notice about the availability of the program, (ii) a description of the incentives available to a
 535 covered person, (iii) instructions on how to earn such incentives, and (iv) notification that tax treatment of the
 536 shared savings amounts or awards will be compliant with the rules of the Internal Revenue Service and
 537 treated as taxable income.

538 G. A comparable health care service incentive payment made by a health carrier in accordance with this
 539 section shall not constitute an administrative expense of the health carrier for rate development or rate filing
 540 purposes.

541 H. Prior to offering the program to any covered person, a health carrier shall file with the Commission a
 542 description of the program in the manner determined by the Commission. The description shall include a
 543 demonstration by the health carrier that the program is cost-effective, including any data relied upon by the
 544 health carrier in making such determination. The Commission may review the filing made by the health
 545 carrier to determine if the health carrier's program complies with the requirements of this article.

546 I. A health carrier may petition the Commission to be excluded from participation in the program. The
 547 Commission shall exempt from the program a health plan with a limited provider network that demonstrates
 548 that the network is incompatible with a shared savings program. In making its determination, the Commission
 549 shall consider the impact on premiums related to the administration of the program.

550 J. Annually by April 1, each health carrier shall file with the Commission, for the most recent calendar
 551 year, the total number of comparable health care service incentive payments made pursuant to this article, the

552 use of comparable health care services by category of service for which comparable health care service
553 incentives are made, the total payments made to covered persons, the average amount of incentive payments
554 made by service for such transactions, the total savings achieved below the average allowed amount by
555 service for such transactions, and the total number and percentage of a health carrier's covered persons in
556 small group health benefit plans that participated in such transactions.

557 ~~K. Beginning no later than 18 months after implementation of comparable health care service incentive
558 programs under this section and annually by November 1 of each year thereafter, the Commission shall
559 submit an aggregate report for all health carriers filing the information required by this section to the chairs of
560 the House Committee on Labor and Commerce and Senate Committee on Commerce and Labor.~~

561 **§ 38.2-4214. Application of certain provisions of law.**

562 No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter,
563 §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305,
564 38.2-316, 38.2-316.1, 38.2-316.2, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413,
565 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, 38.2-700 through 38.2-705, 38.2-900 through
566 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, and 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et
567 seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through
568 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through
569 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1
570 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.20, 38.2-3409, 38.2-3411 through 38.2-3419.1 38.2-
571 3419, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of
572 Chapter 34, §§ 38.2-3501 and 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504,
573 §§ 38.2-3514.1 and 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement
574 policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3541.2, 38.2-3542,
575 and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.),
576 §§ 38.2-3600 through 38.2-3607 and 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et
577 seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.)
578 shall apply to the operation of a plan.

579 **§ 38.2-4319. Statutory construction and relationship to other laws.**

580 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter,
581 §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225,
582 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-316.2, 38.2-322, 38.2-325, 38.2-326, 38.2-400,
583 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et
584 seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.),
585 § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1
586 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2
587 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17
588 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1,
589 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3,
590 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.19, 38.2-3418.21, 38.2-3418.22,
591 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.)
592 of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1,
593 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542,
594 and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.),
595 § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et
596 seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall be applicable to any health
597 maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or
598 health services plan licensed and regulated in conformance with the insurance laws or Chapter 42
599 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

600 B. For plans administered by the Department of Medical Assistance Services that provide benefits
601 pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except
602 this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200,
603 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322,
604 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, and 38.2-600 through 38.2-629,
605 Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2
606 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5
607 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1
608 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401,
609 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and
610 38.2-3407.9:02, subsection E of § 38.2-3407.10, §§ 38.2-3407.10:1, 38.2-3407.11, 38.2-3407.11:3,
611 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3418.16,
612 38.2-3419.1, 38.2-3430.1 through 38.2-3437, and 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of
613 § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1,

614 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55
 615 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66
 616 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance organization granted a license under this
 617 chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in
 618 conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities
 619 of its health maintenance organization.

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

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

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

629 F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B
 630 shall be construed to mean and include "health maintenance organizations" unless the section cited clearly
 631 applies to health maintenance organizations without such construction.

632 **§ 38.2-5904. Office of the Managed Care Ombudsman established; responsibilities.**

633 A. The Commission shall create within the Bureau of Insurance the Office of the Managed Care
 634 Ombudsman. The Office of the Managed Care Ombudsman shall promote and protect the interests of covered
 635 persons under managed care health insurance plans in the Commonwealth. All state agencies shall assist and
 636 cooperate with the Office of the Managed Care Ombudsman in the performance of its duties under this
 637 chapter. The definitions in § 32.1-137.7 shall have the same meanings ascribed to them in § 32.1-137.7 when
 638 used in this section.

639 B. The Office of the Managed Care Ombudsman shall:

640 1. Assist covered persons in understanding their rights and the processes available to them according to
 641 their managed care health insurance plan.

642 2. Answer inquiries from covered persons and other citizens by telephone, mail, electronic mail and in
 643 person.

644 3. Provide to covered persons and other citizens information concerning managed care health insurance
 645 plans and other utilization review entities upon request.

646 4. Develop information on the types of managed care health insurance plans available in the
 647 Commonwealth, including mandated benefits and utilization review procedures and appeals, and receive and
 648 analyze the annual complaint data required to be filed by each health carrier providing a managed care health
 649 insurance plan, as provided in subsection C of § 38.2-5804.

650 5. Make available, either separately or through an existing Internet Web site utilized by the Bureau of
 651 Insurance, information as set forth in subdivision 4 and such additional information as may be deemed
 652 appropriate.

653 6. In conjunction with complaint and inquiry data maintained by the Bureau of Insurance, maintain data
 654 on inquiries received, the types of assistance requested, any actions taken and the disposition of each such
 655 matter.

656 7. Upon request, assist covered persons in using the procedures and processes available to them from their
 657 managed care health insurance plan, including all utilization review appeals. Such assistance may require the
 658 review of insurance and health care records of a covered person, which shall be done only with that person's
 659 express written consent. The confidentiality of any such medical records shall be maintained in accordance
 660 with the confidentiality and disclosure laws of the Commonwealth.

661 8. Ensure that covered persons have access to the services provided through the Office of the Managed
 662 Care Ombudsman and that the covered persons receive timely responses from the representatives of the
 663 Office of the Managed Care Ombudsman to the inquiries.

664 9. Upon request to the Commission by any of the standing committees of the General Assembly having
 665 jurisdiction over insurance or health or the Joint Commission on Health Care, provide to the Commission for
 666 dissemination to the requesting parties assessments of proposed and existing managed care health insurance
 667 laws and other studies of managed care health insurance plan issues.

668 10. Monitor changes in federal and state laws relating to health insurance.

669 11. Provide information to the Commission that will permit the Commission to report annually on the
 670 activities of the Office of the Managed Care Ombudsman to the *Chairs of the* standing committees of the
 671 General Assembly having jurisdiction over insurance and over health and to the Joint Commission on Health
 672 Care. The Commission's report shall be filed by December 1 of each year; and shall include a
 673 summary of significant new developments in federal and state laws relating to health insurance each year.

674 12. Carry out activities as the Commission determines to be appropriate.

675 2. That §§ 38.2-3419.1, 38.2-3445.2, and 38.2-5601 of the Code of Virginia are repealed.