

1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

2 *An Act 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*  
 3 *the Code of Virginia; to amend the Code of Virginia by adding in Article 2 of Chapter 34 of Title 38.2 a*  
 4 *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*  
 5 *Virginia, relating to health insurance; reporting requirements.*

6 [H 618]

7 Approved

8 **Be it enacted by the General Assembly of Virginia:**

9 **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**  
 10 **Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 2**  
 11 **of Chapter 34 of Title 38.2 a section numbered 38.2-3419.2 as follows:**

12 **§ 2.2-2818. Health and related insurance for state employees.**

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

23 Such contribution shall be financed through appropriations provided by law.

24 B. The plan shall:

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

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

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

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

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

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

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

53 3. Include an appeals process for resolution of complaints that shall provide reasonable procedures for the  
 54 resolution of such complaints and shall be published and disseminated to all covered state employees. The  
 55 appeals process shall be compliant with federal rules and regulations governing nonfederal, self-insured  
 56 governmental health plans. The appeals process shall include a separate expedited emergency appeals

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

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

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

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

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

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

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

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

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

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

115 11. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient  
116 following a radical or modified radical mastectomy and 24 hours of inpatient care following a total  
117 mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in  
118 this subdivision shall be construed as requiring the provision of inpatient coverage where the attending

119 physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

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

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

143 14. Include provisions allowing employees to continue receiving health care services for a period of up to  
144 90 days from the date of the primary care physician's notice of termination from any of the plan's provider  
145 panels. The plan shall notify any provider at least 90 days prior to the date of termination of the provider,  
146 except when the provider is terminated for cause.

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

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

157 Notwithstanding the provisions of this subdivision, any provider shall be permitted to continue rendering  
158 health services to any covered employee who is determined to be terminally ill (as defined under §  
159 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, except  
160 when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for  
161 the remainder of the employee's life for care directly related to the treatment of the terminal illness.

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

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

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

171 For purposes of this subdivision:

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

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

177 "Multiple project assurance contract" means a contract between an institution and the federal Department  
178 of Health and Human Services that defines the relationship of the institution to the federal Department of  
179 Health and Human Services and sets out the responsibilities of the institution and the procedures that will be

180 used by the institution to protect human subjects.

181 "NCI" means the National Cancer Institute.

182 "NIH" means the National Institutes of Health.

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

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

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

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

193 a. The National Cancer Institute;

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

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

196 d. The federal Department of Veterans Affairs; or

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

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

201 Coverage under this subdivision shall apply only if:

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

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

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

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

214 17. Include coverage for biologically based mental illness.

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

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

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

230 18. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery  
231 or such other methods as may be recognized by the National Institutes of Health as effective for the long-term  
232 reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments,  
233 and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for  
234 morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National  
235 Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100  
236 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan  
237 Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared  
238 with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep  
239 apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used  
240 herein, "BMI" equals weight in kilograms divided by height in meters squared.

241 19. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult

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

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

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

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

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

273 D. For the purposes of this section:

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

280 "Standard reference compendia" means:

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

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

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

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

298 G. The plan shall include, in each planning district, at least two health coverage options, each sponsored  
 299 by unrelated entities. No later than July 1, 2006, one of the health coverage options to be available in each  
 300 planning district shall be a high deductible health plan that would qualify for a health savings account  
 301 pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

302 In each planning district that does not have an available health coverage alternative, the Department shall  
 303 voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide

304 coverage under the plan.

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

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

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

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

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

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

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

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

337 The Ombudsman shall:

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

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

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

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

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

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

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

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

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

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

361 For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage  
362 reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until  
363 the covered employee notifies the plan in writing of the assignment.

364 N. Beginning July 1, 2006, any plan established pursuant to this section shall provide for an identification

365 number, which shall be assigned to the covered employee and shall not be the same as the employee's social  
366 security number.

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

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

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

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

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

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

401 **§ 38.2-3419.2. Inventory of mandated benefits and providers.**

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

406 **§ 38.2-3445.02. Arbitration; provider termination and reinstatement; reporting requirements.**

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

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

420 C. Within seven calendar days of receipt of notification from the initiating party, the Commission shall  
421 provide the parties with a list of approved arbitrators or entities that provide arbitrations. The arbitrators on  
422 the list shall not have a conflict of interest with the parties and shall be trained and have experience and be  
423 selected by the Commission as set out in the standards established by the Commission through regulation.  
424 The parties may agree on an arbitrator from the list provided by the Commission. If the parties do not agree  
425 on an arbitrator, they shall notify the Commission, and the Commission shall provide the parties with the  
426 names of five arbitrators from the list. Each party may veto up to two of the five named arbitrators. If one

427 arbitrator remains, that arbitrator shall be the chosen arbitrator. If more than one arbitrator remains, the  
 428 Commission shall choose the arbitrator from the remaining arbitrators. The parties and the Commission shall  
 429 complete this process within 20 calendar days of receipt of the original list from the Commission.

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

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

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

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

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

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

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

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

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

469 J. The Commission shall prepare an annual report summarizing the dispute resolution information  
 470 provided by arbitrators, including information related to the matters decided through arbitration as well as the  
 471 following information ~~for provided by health carriers pursuant to subsection I.~~ For each dispute resolved  
 472 through arbitration: *, the report shall include the name of the carrier, the name of the health care provider, the  
 473 health care provider's employer or the business entity in which the provider has an ownership interest name of  
 474 the filing party, the health care facility where the services were provided rendered, and the type of health care  
 475 services at issues issue, and in which party's favor the dispute was resolved. The report shall also include (i)  
 476 the number and type of claims resolved by arbitration; (ii) aggregate information on the disposition of such  
 477 arbitrations, including in which party's favor the dispute was resolved; (iii) aggregate information on the  
 478 variation between the initial payment and final settlement amounts; (iv) the number of health care providers  
 479 in the health carrier's network of emergency services providers and surgical or ancillary services providers  
 480 whose participation in the network was terminated by the health carrier or the health care provider in the  
 481 previous year and whose participation was subsequently reinstated in the same year; and (v) a summary of  
 482 the nature and extent of differences in payment levels prior to termination and after reinstatement, if  
 483 applicable, including a determination of whether such payment levels after reinstatement were higher or  
 484 lower than those applied prior to termination.* The Commission shall post the report on the Bureau's website  
 485 and submit it to the Chairs of the House Committee on Labor and Commerce and Committee on  
 486 Appropriations and the Senate Committee on Commerce and Labor and Committee on Finance and  
 487 Appropriations annually by ~~July~~ *December 1.* The provisions of this subsection shall expire on ~~July 1, 2025~~  
 488 *December 1, 2030.*

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

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

497 **§ 38.2-3462. Comparable Health Care Service Incentive Program.**

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

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

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

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

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

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

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

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

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

546 J. Annually by April 1, each health carrier shall file with the Commission, for the most recent calendar  
 547 year, the total number of comparable health care service incentive payments made pursuant to this article, the  
 548 use of comparable health care services by category of service for which comparable health care service  
 549 incentives are made, the total payments made to covered persons, the average amount of incentive payments  
 550 made by service for such transactions, the total savings achieved below the average allowed amount by

551 service for such transactions, and the total number and percentage of a health carrier's covered persons in  
 552 small group health benefit plans that participated in such transactions.

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

557 **§ 38.2-4214. Application of certain provisions of law.**

558 No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter,  
 559 §§ 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,  
 560 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,  
 561 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  
 562 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  
 563 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  
 564 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  
 565 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  
 566 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~~  
 567 ~~38.2-3419~~, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of  
 568 Chapter 34, §§ 38.2-3501 and 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504,  
 569 §§ 38.2-3514.1 and 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement  
 570 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,  
 571 and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.),  
 572 §§ 38.2-3600 through 38.2-3607 and 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et  
 573 seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.)  
 574 shall apply to the operation of a plan.

575 **§ 38.2-4319. Statutory construction and relationship to other laws.**

576 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter,  
 577 §§ 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,  
 578 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,  
 579 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  
 580 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.),  
 581 § 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  
 582 (§ 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  
 583 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17  
 584 (§ 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,  
 585 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,  
 586 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,  
 587 ~~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.)  
 588 of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1,  
 589 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,  
 590 and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.),  
 591 § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et  
 592 seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall be applicable to any health  
 593 maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or  
 594 health services plan licensed and regulated in conformance with the insurance laws or Chapter 42  
 595 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

596 B. For plans administered by the Department of Medical Assistance Services that provide benefits  
 597 pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except  
 598 this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200,  
 599 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,  
 600 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,  
 601 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  
 602 (§ 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  
 603 (§ 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  
 604 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401,  
 605 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  
 606 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,  
 607 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,  
 608 ~~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  
 609 § 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,  
 610 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  
 611 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66  
 612 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance organization granted a license under this

chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

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

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

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

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

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

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

B. The Office of the Managed Care Ombudsman shall:

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

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

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

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

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

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

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

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

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

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

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

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

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