

1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

2 *An Act to amend and reenact §§ 2.2-4006, 32.1-137.3, 32.1-276.7:1, and 38.2-3412.1 of the Code of Virginia,*
 3 *relating to mental health and substance abuse disorders; network adequacy standards; comparative*
 4 *analyses; report.*

5 [H 656]

6 Approved

7 **Be it enacted by the General Assembly of Virginia:**8 **1. That §§ 2.2-4006, 32.1-137.3, 32.1-276.7:1, and 38.2-3412.1 of the Code of Virginia are amended and**
 9 **reenacted as follows:**10 **§ 2.2-4006. Exemptions from requirements of this article.**11 A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register
 12 Act shall be exempted from the operation of this article:

13 1. Agency orders or regulations fixing rates or prices.

14 2. Regulations that establish or prescribe agency organization, internal practice or procedures, including
 15 delegations of authority.16 3. Regulations that consist only of changes in style or form or corrections of technical errors. Each
 17 promulgating agency shall review all references to sections of the Code of Virginia within their regulations
 18 each time a new supplement or replacement volume to the Code of Virginia is published to ensure the
 19 accuracy of each section or section subdivision identification listed.

20 4. Regulations that are:

21 a. Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency
 22 discretion is involved. However, such regulations shall be filed with the Registrar within 90 days of the law's
 23 effective date;24 b. Required by order of any state or federal court of competent jurisdiction where no agency discretion is
 25 involved; or26 c. Necessary to meet the requirements of federal law or regulations, provided such regulations do not
 27 differ materially from those required by federal law or regulation, and the Registrar has so determined in
 28 writing. Notice of the proposed adoption of these regulations and the Registrar's determination shall be
 29 published in the Virginia Register not less than 30 days prior to the effective date of the regulation.30 5. Regulations of the Board of Agriculture and Consumer Services adopted pursuant to subsection B of
 31 § 3.2-3929 or clause (v) or (vi) of subsection C of § 3.2-3931 after having been considered at two or more
 32 Board meetings and one public hearing.33 6. Regulations of (i) the regulatory boards served by the Department of Labor and Industry pursuant to
 34 Title 40.1 and the Department of Professional and Occupational Regulation or the Department of Health
 35 Professions pursuant to Title 54.1, (ii) the Board of Accountancy, and (iii) the State Board of Health that are
 36 limited to reducing fees charged to regulants and applicants.37 7. The development and issuance of procedural policy relating to risk-based mine inspections by the
 38 Department of Energy authorized pursuant to §§ 45.2-560 and 45.2-1149.39 8. General permits issued by the (a) State Air Pollution Control Board pursuant to Chapter 13
 40 (§ 10.1-1300 et seq.) of Title 10.1 or (b) State Water Control Board pursuant to the State Water Control Law
 41 (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1 and Chapter 25 (§ 62.1-254 et seq.) of Title
 42 62.1, (c) Virginia Soil and Water Conservation Board pursuant to the Dam Safety Act (§ 10.1-604 et seq.),
 43 and (d) the development and issuance of general wetlands permits by the Marine Resources Commission
 44 pursuant to subsection B of § 28.2-1307, if the respective Board or Commission (i) provides a Notice of
 45 Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (ii) following the passage
 46 of 30 days from the publication of the Notice of Intended Regulatory Action forms a technical advisory
 47 committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the
 48 development of the general permit, (iii) provides notice and receives oral and written comment as provided in
 49 § 2.2-4007.03, and (iv) conducts at least one public hearing on the proposed general permit.50 9. The development and issuance by the Board of Education of guidelines on constitutional rights and
 51 restrictions relating to the recitation of the pledge of allegiance to the American flag in public schools
 52 pursuant to § 22.1-202.

53 10. Regulations of the Board of the Commonwealth Savers Plan adopted pursuant to § 23.1-704.

54 11. Regulations of the Marine Resources Commission.

55 12. Regulations adopted by the Board of Housing and Community Development pursuant to (i) Statewide
 56 Fire Prevention Code (§ 27-94 et seq.), (ii) the Industrialized Building Safety Law (§ 36-70 et seq.), (iii) the

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57 Uniform Statewide Building Code (§ 36-97 et seq.), and (iv) § 36-98.3, provided the Board (a) provides a
 58 Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (b) publishes the
 59 proposed regulation and provides an opportunity for oral and written comments as provided in § 2.2-4007.03,
 60 and (c) conducts at least one public hearing as provided in §§ 2.2-4009 and 36-100 prior to the publishing of
 61 the proposed regulations. Notwithstanding the provisions of this subdivision, any regulations promulgated by
 62 the Board shall remain subject to the provisions of § 2.2-4007.06 concerning public petitions, and
 63 §§ 2.2-4013 and 2.2-4014 concerning review by the Governor and General Assembly.

64 13. Amendments to regulations of the Board to schedule a substance pursuant to subsection D or E of
 65 § 54.1-3443.

66 14. Waste load allocations adopted, amended, or repealed by the State Water Control Board pursuant to
 67 the State Water Control Law (§ 62.1-44.2 et seq.), including but not limited to Article 4.01 (§ 62.1-44.19:4 et
 68 seq.) of the State Water Control Law, if the Board (i) provides public notice in the Virginia Register; (ii) if
 69 requested by the public during the initial public notice 30-day comment period, forms an advisory group
 70 composed of relevant stakeholders; (iii) receives and provides summary response to written comments; and
 71 (iv) conducts at least one public meeting. Notwithstanding the provisions of this subdivision, any such waste
 72 load allocations adopted, amended, or repealed by the Board shall be subject to the provisions of §§ 2.2-4013
 73 and 2.2-4014 concerning review by the Governor and General Assembly.

74 15. Regulations of the Workers' Compensation Commission adopted pursuant to § 65.2-605, including
 75 regulations that adopt, amend, adjust, or repeal Virginia fee schedules for medical services, provided the
 76 Workers' Compensation Commission (i) utilizes a regulatory advisory panel constituted as provided in
 77 subdivision F 2 of § 65.2-605 to assist in the development of such regulations and (ii) provides an opportunity
 78 for public comment on the regulations prior to adoption.

79 16. Amendments to the State Health Services Plan adopted by the Board of Health following receipt of
 80 recommendations by the State Health Services Task Force pursuant to § 32.1-102.2:1 if the Board (i)
 81 provides a Notice of Intended Regulatory Action in accordance with the requirements of § 2.2-4007.01, (ii)
 82 provides notice and receives comments as provided in § 2.2-4007.03, and (iii) conducts at least one public
 83 hearing on the proposed amendments.

84 17. Rules of the Workers' Compensation Commission adopted pursuant to subsection A of § 65.2-201 and
 85 subsection B of § 65.2-703, provided the Workers' Compensation Commission provides an opportunity for
 86 public comment on the rules prior to adoption.

87 18. *Amendments to the network adequacy standards for a managed care health insurance plan adopted by*
 88 *the Board of Health that conform to the network adequacy standards required for qualified health plans and*
 89 *qualified dental plans, as such terms are defined in § 38.2-6500, offered in the Commonwealth, provided that*
 90 *the Board of Health provides an opportunity for public comment on such amendments prior to adoption.*

91 B. Whenever regulations are adopted under this section, the agency shall state as part thereof that it will
 92 receive, consider, and respond to petitions by any interested person at any time with respect to
 93 reconsideration or revision. The effective date of regulations adopted under this section shall be in accordance
 94 with the provisions of § 2.2-4015, except in the case of emergency regulations, which shall become effective
 95 as provided in subsection B of § 2.2-4012.

96 C. A regulation for which an exemption is claimed under this section or § 2.2-4002 or 2.2-4011 and that is
 97 placed before a board or commission for consideration shall be provided at least two days in advance of the
 98 board or commission meeting to members of the public that request a copy of that regulation. A copy of that
 99 regulation shall be made available to the public attending such meeting.

100 **§ 32.1-137.3. Regulations.**

101 Consistent with its duties to protect the health, safety, and welfare of the public, the Board shall
 102 promulgate regulations, consistent with this article, governing the quality of care provided to covered persons
 103 by a managed care health insurance plan licensee through its managed care health insurance plans on or
 104 before December 1, 1999. The regulations may incorporate or apply nationally recognized, generally
 105 accepted, quality standards developed by private accreditation entities, if such standards exist and as
 106 appropriate for the type of managed care health insurance plan. The regulations shall also include ~~guidelines~~:

107 1. *Guidelines* for the Commissioner to determine, in consultation with the Bureau of Insurance, when the
 108 imposition of administrative sanctions as set forth in § 32.1-137.5 or initiation of court proceedings or both
 109 are appropriate in order to ensure prompt correction of violations discovered on any examination, review, or
 110 investigation conducted by the Department pursuant to provisions of this article; *and*

111 2. *Quantitative network adequacy standards for timely access to care, travel time, and geographical*
 112 *distance that are at least as stringent as those required for qualified health plans and qualified dental plans,*
 113 *as such terms are defined in § 38.2-6500, provided in the Commonwealth.*

114 **§ 32.1-276.7:1. All-Payer Claims Database created; purpose; reporting requirements.**

115 A. The Virginia All-Payer Claims Database is hereby created to facilitate data-driven, evidence-based
 116 improvements in access, quality, and cost of health care and to promote and improve the public health
 117 through the understanding of health care expenditure patterns and operation and performance of the health
 118 care system.

119 B. The Commissioner shall ensure that the Department meets the requirements to be a health oversight
120 agency as defined in 45 C.F.R. § 164.501.

121 C. The Commissioner, in cooperation with the Bureau of Insurance, shall collect ~~paid~~ claims data ~~for~~
122 ~~covered benefits~~ from data suppliers, which shall include:

123 1. Issuers of individual or group accident and sickness insurance policies providing hospital, medical and
124 surgical, or major medical coverage on an expense-incurred basis; corporations providing individual or group
125 accident and sickness subscription contracts; and health maintenance organizations providing a health care
126 plan for health care services, for at least 1,000 covered lives in the most recent calendar year;

127 2. Third-party administrators and any other entities that receive or collect charges, contributions, or
128 premiums for, or adjust or settle health care claims for, at least 1,000 Virginia covered lives on behalf of
129 group health plans other than ERISA plans;

130 3. Third-party administrators, and any other entities, that receive or collect charges, contributions, or
131 premiums for, or adjust or settle health care claims for, an employer that maintains an ERISA plan that has
132 opted-in to data submission to the All-Payer Claims Database pursuant to subsection P;

133 4. The Department of Medical Assistance Services with respect to services provided under programs
134 administered pursuant to Titles XIX and XXI of the Social Security Act;

135 5. State government health insurance plans;

136 6. Local government health insurance plans, subject to their ability to provide such data and to the extent
137 permitted by state and federal law; and

138 7. Federal health insurance plans, to the extent permitted by federal law, including Medicare, TRICARE,
139 and the Federal Employees Health Benefits Plan.

140 Such collection of ~~paid~~ claims data ~~for covered benefits~~ shall not include data related to Medigap,
141 disability income, workers' compensation claims, standard benefits provided by long-term care insurance,
142 disease specific health insurance, dental or vision claims, or other supplemental health insurance products;

143 D. The Commissioner shall ensure that the nonprofit organization executes a standard data submission
144 and use agreement with each entity listed in subsection ~~B~~ C that submits ~~paid~~ claims data to the All-Payer
145 Claims Database and each entity that subscribes to data products and reports. Such agreements shall include
146 procedures for submission, collection, aggregation, and distribution of specified data. Additionally, the
147 Commissioner shall ensure that the nonprofit organization:

148 1. Protects patient privacy and data security pursuant to provisions of this chapter and state and federal
149 privacy laws, including the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et
150 seq., as amended); Titles XIX and XXI of the Social Security Act; § 32.1-127.1:03; Chapter 6 (§ 38.2-600 et
151 seq.) of Title 38.2; and the Health Information Technology for Economic and Clinical Health (HITECH) Act,
152 as included in the American Recovery and Reinvestment Act (P.L. 111-5, 123 Stat. 115) as if the nonprofit
153 organization were covered by such laws;

154 2. Identifies the type of ~~paid~~ claims to be collected by the All-Payer Claims Database and the entities that
155 are subject to the submission of such claims as well as identification of specific data elements from existing
156 claims systems to be submitted and collected, including but not limited to patient demographics, diagnosis
157 and procedure codes, provider information, plan payments, member payment responsibility, and service
158 dates;

159 3. Administers the All-Payer Claims Database in a manner to allow for geographic, demographic,
160 economic, and peer group comparisons;

161 4. Develops public analyses identifying and comparing health plans by public and private health care
162 purchasers, providers, employers, consumers, health plans, health insurers, and data analysts, health insurers,
163 and providers with regard to their provision of safe, cost-effective, and high-quality health care services;

164 5. Uses common data layout or other national data collection standards and methods that utilize a standard
165 set of core data elements for data submissions, as adopted or endorsed by the APCD Council, to establish and
166 maintain the database in a cost-effective manner and to facilitate uniformity among various all-payer claims
167 databases of other states and specification of data fields to be included in the submitted claims, consistent
168 with such national standards, allowing for exemptions when submitting entities do not collect the specified
169 data or pay on a per-claim basis, such exemption process to be managed by the advisory committee created
170 pursuant to subsection E;

171 6. Does not disclose or report provider-specific, facility-specific, or carrier-specific reimbursement
172 information, or information capable of being reverse-engineered, combined, or otherwise used to calculate or
173 derive such reimbursement information, from the All-Payer Claims Database;

174 7. Promotes the responsible use of claims data to improve health care value and preserve the integrity and
175 utility of the All-Payer Claims Database; and

176 8. Requires that all public reports and analyses comparing providers or health plans using data from the
177 All-Payer Claims Database use national standards or, when such national standards are unavailable, provide
178 full transparency to providers or health plans of the alternative methodology used.

179 E. The Commissioner shall establish an advisory committee to assist in the formation and operation of the
180 All-Payer Claims Database. Such committee shall consist of (i) a representative from each of the following: a

181 statewide hospital association, a statewide association of health plans, a professional organization
182 representing physicians, a professional organization representing pharmacists, an organization that processes
183 insurance claims or certain aspects of employee benefits plans for a separate entity, a community mental
184 health center who has experience in behavioral health data collection, a nursing home health care provider
185 who has experience with medical claims data, a nonprofit health insurer, and a for-profit health insurer; (ii)
186 up to two representatives with a demonstrated record of advocating health care issues on behalf of
187 consumers; (iii) two representatives of hospitals or health systems; (iv) an individual with academic
188 experience in health care data and cost-efficiency research; (v) a representative who is not a supplier or
189 broker of health insurance from small employers that purchase group health insurance for employees; (vi) a
190 representative who is not a supplier or broker of health insurance from large employers that purchase health
191 insurance for employees, and (vii) a representative who is not a supplier or broker of health insurance from
192 self-insured employers, all of whom shall be appointed by the Commissioner. The Commissioner, the
193 chairman of the board of directors of the nonprofit organization, the Commissioner of Insurance, the Director
194 of the Department of Medical Assistance Services, the Director of the Department of Human Resource
195 Management, or their designees, shall serve ex officio.

196 In appointing members to the advisory committee, the Commissioner shall adopt reasonable measures to
197 select representatives in a manner that provides balanced representation within and among the appointments
198 and that any representative appointed is without any actual or apparent conflict of interest, including conflicts
199 of interest created by virtue of the individual's employer's corporate affiliations or ownership interests.

200 The nonprofit organization shall provide the advisory committee with details at least annually on the use
201 and disclosure of All-Payer Claims Database data, including reports developed by the nonprofit organization;
202 details on methods used to extract, transform, and load data; and efforts to protect patient privacy and data
203 security.

204 The meetings of the advisory committee shall be open to the public.

205 F. The Commissioner shall establish a data release committee to review and approve requests for access to
206 data. The data release committee shall consist of the Commissioner or his designee, and upon
207 recommendation of the advisory committee, the Commissioner shall appoint an individual with academic
208 experience in health care data and cost-efficiency research; a representative of a health insurer; a health care
209 practitioner; a representative from a hospital with a background in administration, analytics, or research; and
210 a representative with a demonstrated record of advocating health care issues on behalf of consumers. In
211 making its recommendations, the advisory committee shall adopt reasonable measures to select
212 representatives in a manner that provides balanced representation within and among the appointments and
213 that any representative appointed is without any actual or apparent conflict of interest, including conflicts of
214 interest created by virtue of the individual's employer's corporate affiliations or ownership interests. The data
215 release committee shall ensure that (i) all data approvals are consistent with the purposes of the All-Payer
216 Claims Database as provided in subsection A; (ii) all data approvals comply with applicable state and federal
217 privacy laws and state and federal laws regarding the exchange of price and cost information to protect the
218 confidentiality of the data and encourage a competitive marketplace for health care services; and (iii) the level
219 of detail, as provided in subsection H, is appropriate for each request and is accompanied by a standardized
220 data use agreement.

221 G. The nonprofit organization shall implement the All-Payer Claims Database, consistent with the
222 provisions of this chapter, to include:

223 1. The reporting of data that can be used to improve public health surveillance and population health,
224 including reports on (i) injuries; (ii) chronic diseases, including but not limited to asthma, diabetes,
225 cardiovascular disease, hypertension, arthritis, and cancer; (iii) health conditions of pregnant women, infants,
226 and children; and (iv) geographic and demographic information for use in community health assessment,
227 prevention education, and public health improvement. This data shall be developed in a format that allows
228 comparison of information in the All-Payer Claims Database with other nationwide data programs and that
229 allows employers to compare their employee health plans statewide and between and among regions of the
230 Commonwealth and nationally.

231 2. The reporting of data that payers, providers, and health care purchasers, including employers and
232 consumers, may use to compare quality and efficiency of health care, including development of information
233 on utilization patterns and information that permits comparison of health plans and providers statewide
234 between and among regions of the Commonwealth. The advisory committee created pursuant to subsection E
235 shall make recommendations to the nonprofit organization on the appropriate level of specificity of reported
236 data in order to protect patient privacy and to accurately attribute services and resource utilization rates to
237 providers.

238 3. The reporting of data that permits design and evaluation of alternative delivery and payment models.

239 4. The reporting and release of data consistent with the purposes of the All-Payer Claims Database as set
240 forth in subsection A as determined to be appropriate by the data release committee created pursuant to
241 subsection F.

242 H. Except as provided in subsection O, the nonprofit organization shall not provide data or access to data

243 without the approval of the data release committee. Upon approval, the nonprofit organization may provide
 244 data or access to data at levels of detail that may include (i) aggregate reports, which are defined as data
 245 releases with all observation counts greater than 10; (ii) de-identified data sets that meet the standard set forth
 246 in 45 C.F.R. § 164.514(a); and (iii) limited data sets that comply with the National Institutes of Health
 247 guidelines for release of personal health information.

248 I. Reporting of data shall not commence until such data has been processed and verified at levels of
 249 accuracy consistent with existing nonprofit organization data standards. Prior to public release of any report
 250 specifically naming any provider or payer, or public reports in which an individual provider or payers
 251 represents 60 percent or more of the data, the nonprofit organization shall provide affected entities with
 252 notice of the pending report and allow for a 30-day period of review to ensure accuracy. During this period,
 253 affected entities may seek explanations of results and correction of data that they prove to be inaccurate. The
 254 nonprofit organization shall make these corrections prior to any public release of the report. At the end of the
 255 review period, upon completion of all necessary corrections, the report may be released. For the purposes of
 256 this subsection, "public release" means the release of any report to the general public and does not include the
 257 preparation of reports for, or use of the All-Payer Claims Database by, organizations that have been approved
 258 for access by the data release committee and have entered into written agreements with the nonprofit
 259 organization.

260 J. The Commissioner and the nonprofit organization shall consider and recommend, as appropriate,
 261 integration of new data sources into the All-Payer Claims Database, based on the findings and
 262 recommendations of the advisory committee.

263 K. Information acquired pursuant to this section shall be confidential and shall be exempt from disclosure
 264 by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). The reporting and release of data pursuant
 265 to this section shall comply with all state and federal privacy laws and state and federal laws regarding the
 266 exchange of price and cost information to protect the confidentiality of the data and encourage a competitive
 267 marketplace for health care services.

268 L. No person shall assess costs or charge a fee to any health care practitioner related to formation or
 269 operation of the All-Payer Claims Database. However, a reasonable fee may be charged to health care
 270 practitioners who voluntarily access the All-Payer Claims Database for purposes other than data verification.

271 M. As used in this section, "provider" means a hospital or physician as defined in this chapter or any other
 272 health care practitioner licensed, certified, or authorized under state law to provide covered services
 273 represented in claims reported pursuant to this section.

274 N. The Commissioner, in consultation with the board of directors of the nonprofit organization, shall
 275 develop short-term and long-term funding strategies for the operation of the All-Payer Claims Database to
 276 provide necessary funding in excess of any budget appropriation by the Commonwealth.

277 O. The nonprofit organization, the Department of Health, the Department of Medical Assistance Services,
 278 and the Bureau of Insurance shall have access to data reported by the All-Payer Claims Database pursuant to
 279 this section at no cost for the purposes of public health improvement research and activities.

280 P. Each employer that maintains an ERISA plan may opt-in to allow a third-party ~~administer~~
 281 *administrator* or other entity to submit data to the All-Payer Claims Database. For any such employer that
 282 opts-in, the third-party administrator or other entity shall (i) submit data for the next reporting period after the
 283 opt-in and all future reporting periods until the employer opts-out and (ii) include data from any such
 284 employer as part of its data submission, if any, otherwise required by this section. Such an employer may
 285 opt-out at any time but shall provide written notice to the third-party administrator or other entity of its
 286 decision at least 30 days prior to the start of the next reporting period. No employer that maintains an ERISA
 287 plan shall be required to opt-in to data submission to the All-Payer Claims Database, and no third-party
 288 administrator or other entity shall be required to submit claims processed before it was contracted to provide
 289 services. Each third-party administrator or other entity providing claim administration services for an
 290 employer shall submit annually to the nonprofit organization by January 31 of each year a list of the ERISA
 291 plans whose employer has opted-in to data submission to the All-Payer Claims Database and a list identifying
 292 all employers that maintain an ERISA plan with Virginia employees for which it provides claim
 293 administration services. Such information submitted shall be considered proprietary and shall be exempt from
 294 disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

295 Q. Any data release shall make use of a masked proxy reimbursement amount, for which the methodology
 296 is publicly available and approved by the data release committee except that the Department may request that
 297 the nonprofit organization generate the following reports based on actual reimbursement amounts: (i) the total
 298 cost burden of a disease, chronic disease, injury, or health condition across the state, health planning region,
 299 health planning district, county, or city, provided that the total cost shall be an aggregate amount
 300 encompassing costs attributable to all data suppliers and not identifying or attributable to any individual
 301 provider, and (ii) any analyses to determine the average reimbursement that is paid for health care services
 302 that may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain
 303 conditions or diseases. Any additional report of analysis based on actual reimbursement amounts shall require
 304 the approval of the data release committee.

305 R. The nonprofit organization shall ensure the timely reporting of information by private data suppliers to
 306 meet the requirements of this section. The nonprofit organization shall notify private data suppliers of any
 307 applicable reporting deadlines. The nonprofit shall notify, in writing, a private data supplier of a failure to
 308 meet a reporting deadline, and that failure to respond within two weeks following receipt of the written notice
 309 may result in a penalty. The Board may assess a civil penalty of up to \$1,000 per week per violation, not to
 310 exceed a total of \$50,000 per violation, against a private data supplier that fails, within its determination, to
 311 make a good faith effort to provide the requested information within two weeks following receipt of the
 312 written notice required by this subsection. Civil penalties assessed under this subsection shall be maintained
 313 by the Department and used for the ongoing improvement of the All-Payer Claims Database.

314 **§ 38.2-3412.1. Coverage for mental health and substance use disorders.**

315 A. As used in this section:

316 "Adult" means any person who is 19 years of age or older.

317 "Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the
 318 treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State
 319 Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of Behavioral
 320 Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii)
 321 a state agency or institution.

322 "Child or adolescent" means any person under the age of 19 years.

323 "Crisis receiving center" means a community-based facility licensed by the Department of Behavioral
 324 Health and Developmental Services to provide short-term assessment, observation, and crisis stabilization
 325 services.

326 "Generally accepted standards of mental health or substance use disorder care" means evidence-based
 327 independent standards of care and clinical practice that are generally recognized by health care providers
 328 practicing in relevant clinical specialties including child and adolescent psychiatry, adult psychiatry,
 329 psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Sources
 330 reflecting "generally accepted standards of mental health or substance use disorder care" include
 331 peer-reviewed scientific studies and medical literature, consensus guidelines and recommendations of
 332 nonprofit health care provider professional associations and specialty societies, and nationally recognized
 333 clinical practice guidelines, including patient placement criteria, service intensity assessment instruments,
 334 clinical practice guidelines, guidelines and recommendations of federal government agencies, and drug
 335 labeling approved by the U.S. Food and Drug Administration. Nothing in this section shall supersede the
 336 standard of care as set forth in § 8.01-581.20.

337 "Inpatient treatment" means mental health or substance abuse services delivered on a 24-hour per day
 338 basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a
 339 mental health treatment center.

340 "Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and
 341 that is operated primarily for the purpose of providing a continuous, structured 24-hour per day, state-
 342 approved program of inpatient substance abuse services.

343 "Medically necessary" means, with respect to the treatment of a mental health or substance use disorder, a
 344 service or product addressing the specific needs of a patient for the purpose of screening, preventing,
 345 diagnosing, managing, or treating such disorder, including minimizing the progression of such disorder, in a
 346 manner that is in accordance with generally accepted standards of mental health or substance use disorder
 347 care; clinically appropriate in terms of type, frequency, extent, site, and duration; and not defined primarily
 348 for the economic benefit of an insurer or purchaser or for the convenience of the patient, treating physician, or
 349 other health care provider.

350 "Medication management visit" means a visit no more than 20 minutes in length with a licensed physician
 351 or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and
 352 adjusting medications prescribed for mental health or substance abuse treatment.

353 "Mental health services" or "mental health benefits" means *services or benefits with respect to items or*
 354 *services for mental health conditions as defined under the terms of the health benefit plan. Any condition*
 355 *defined by the health benefit plan as being or as not being a mental health condition shall be defined to be*
 356 *consistent with generally recognized independent standards of current medical practice for all conditions,*
 357 *except for substance use disorders, that fall under the diagnostic categories listed in the Mental, Behavioral,*
 358 *and Neurodevelopmental Disorders chapter, or equivalent chapter, of the most current version of the*
 359 *International Classification of Diseases of the World Health Organization or in the most current version of*
 360 *the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

361 "Mental health treatment center" means a treatment facility organized to provide care and treatment for
 362 mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored
 363 by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The
 364 facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state
 365 law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient
 366 referral.

367 "Mobile crisis response services" means services licensed by the Department of Behavioral Health and
 368 Developmental Services to provide for rapid response to, assessment of, and early intervention for individuals
 369 experiencing an acute mental health crisis that are deployed at the location of the individual.

370 "Network adequacy" means access to services by measure of distance, time, and average length of referral
 371 to scheduled visit.

372 "Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as
 373 an individual or part of a group while not confined as an inpatient. Such treatment shall not include services
 374 delivered through a partial hospitalization or intensive outpatient program as defined herein.

375 "Partial hospitalization" means a licensed or approved day or evening treatment program that includes the
 376 major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for
 377 patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require
 378 coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide
 379 treatment over a period of six or more continuous hours per day to individuals or groups of individuals who
 380 are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of
 381 alcohol or other drug dependence which provide treatment over a period of three or more continuous hours
 382 per day to individuals or groups of individuals who are not admitted as inpatients.

383 "Residential crisis stabilization unit" means a community-based, short-term residential program licensed
 384 by the Department of Behavioral Health and Developmental Services to provide short-term assessment,
 385 observation, support, and crisis stabilization for individuals who are experiencing an acute mental health
 386 crisis.

387 "Substance abuse services" or "substance use disorder benefits" means ~~services or benefits with respect to~~
 388 ~~items or services for substance use disorders as defined under the terms of the health benefit plan. Any~~
 389 ~~disorder defined by the health benefit plan as being or as not being a substance use disorder shall be defined~~
 390 ~~to be consistent with generally recognized independent standards of current medical practice for all~~
 391 ~~conditions that fall under the diagnostic categories for substance use disorders in the Mental, Behavioral,~~
 392 ~~and Neurodevelopmental Disorders chapter, or equivalent chapter, of the most current version of the~~
 393 ~~International Classification of Diseases of the World Health Organization or in the Substance-Related and~~
 394 ~~Addictive Disorders section, or equivalent section, of the most current version of the Diagnostic and~~
 395 ~~Statistical Manual of Mental Disorders of the American Psychiatric Association.~~

396 "Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care,
 397 and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered
 398 by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center,
 399 a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional
 400 counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist or clinical
 401 nurse specialist. Treatment for physiological or psychological dependence on alcohol or other drugs shall also
 402 include the services of counseling and rehabilitation as well as services rendered by a state certified
 403 alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope
 404 of practice set forth in § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed
 405 to provide such treatment.

406 B. Except as provided in subsections C and D, group and individual health insurance coverage, as defined
 407 in § 38.2-3431, shall provide coverage for mental health and substance use disorder benefits for children,
 408 adolescents, and adults. Such benefits shall be in parity with the medical and surgical benefits contained in
 409 the coverage in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008
 410 (MHPAEA), P.L. 110-343, even where those requirements would not otherwise apply directly, and shall
 411 apply the definitions of "generally accepted standards of mental health or substance use disorder care" and
 412 "medically necessary" provided in subsection A for any determination of medical necessity, prior
 413 authorization, or utilization review under such coverage. In conducting utilization review involving decisions
 414 within the scope of generally accepted standards of mental health or substance use disorder care, no insurer
 415 providing such coverage shall apply criteria that are different from, additional to, conflicting with, or more
 416 restrictive than the criteria set forth in such generally accepted standards. Coverage required under this
 417 subsection shall include mobile crisis response services and support and stabilization services provided in a
 418 residential crisis stabilization unit or crisis receiving center to the extent that such services are covered in
 419 other settings or modalities, regardless of any difference in billing codes. *The Commission may promulgate*
 420 *regulations as necessary to implement the provisions of this subsection, including by adopting or*
 421 *incorporating, in whole or in part, federal regulations related to implementing the federal Mental Health*
 422 *Parity and Addiction Equity Act as published in 89 Fed. Reg. 77735-77751 on September 23, 2024.*

423 C. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall either continue to
 424 provide benefits in accordance with subsection B or continue to provide coverage for inpatient and partial
 425 hospitalization mental health and substance abuse services as follows:

426 1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center,
 427 alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20 days per policy
 428 or contract year.

429 2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health
 430 treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of
 431 25 days per policy or contract year.

432 3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be
 433 converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a
 434 child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall
 435 be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of
 436 coverage. An insurance policy or subscription contract described herein that provides inpatient benefits in
 437 excess of 20 days per policy or contract year for adults or 25 days per policy or contract year for a child or
 438 adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

439 4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other
 440 illness, except that the benefits may be limited as set out in this subsection.

441 5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to
 442 policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social
 443 Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

444 D. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall also either continue
 445 to provide benefits in accordance with subsection B or continue to provide coverage for outpatient mental
 446 health and substance abuse services as follows:

447 1. A minimum of 20 visits for outpatient treatment of an adult, child, or adolescent shall be provided in
 448 each policy or contract year.

449 2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of
 450 benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit
 451 beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.

452 3. For the purpose of this ~~section~~ subsection, medication management visits shall be covered in the same
 453 manner as a medication management visit for the treatment of physical illness and shall not be counted as an
 454 outpatient treatment visit in the calculation of the benefit set forth herein.

455 4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or
 456 substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not
 457 count toward the outpatient visit benefit maximum set forth in the policy or contract.

458 5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to
 459 policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social
 460 Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

461 E. 1. *Each health carrier shall submit to the Bureau, on the date and frequency as specified by the*
 462 *Bureau, which shall be no less frequently than every two years, all comparative analyses prepared by the*
 463 *carrier pursuant to 42 U.S.C. § 300gg-26(a)(8). The Bureau shall make current comparative analyses*
 464 *publicly available. Publication of the comparative analyses or information linked on the Commission's*
 465 *website shall not constitute approval or a determination of compliance by the Bureau. The Bureau may*
 466 *require a health carrier to provide supplementary data as the Bureau deems relevant for the purposes of*
 467 *evaluating a comparative analysis.*

468 2. *With respect to a comparative analysis prepared by a carrier pursuant to 42 U.S.C. § 300gg-26(a)(8),*
 469 *the Bureau shall request the following quantitative data for medical and surgical benefits, mental health*
 470 *benefits, and substance use disorder benefits:*

471 a. *The number and percentage of denied claims, denied prior authorizations, denied concurrent reviews,*
 472 *and denied retrospective reviews;*

473 b. *The number and percentage of complaints and appeals, including reasons for complaints and outcomes*
 474 *of appeals;*

475 c. *The number and percentage of out-of-network claims;*

476 d. *The frequency and number of prior authorizations, concurrent reviews, and retrospective reviews;*

477 e. *Reimbursement rates, by provider type, benchmarked to a national standard, billed amount, or other*
 478 *basis;*

479 f. *The number and percentage of insured individuals for whom the quantitative network adequacy*
 480 *standards were met;*

481 g. *The average and median number of days to approve or deny a credentialing application;*

482 h. *Metrics regarding the timeliness of updating provider directories upon the addition of a new provider*
 483 *or the termination of a provider contract and the number of providers in the directory accepting new*
 484 *patients;*

485 i. *The number and percentage of providers of each specialty who received reimbursement; and*

486 j. *Other quantitative data that the Bureau may require.*

487 3. *Based on an initial review of comparative analyses and supplementary data, the Bureau may initiate a*
 488 *market conduct examination pursuant to § 38.2-1317.1 or an inquiry to evaluate compliance regarding the*
 489 *federal Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and state mental health or*
 490 *substance use disorder requirements.*

491 4. A noncompliant or insufficient comparative analysis shall constitute a violation of subsection B. In
492 addition to the authority granted to the Bureau under this title, the Bureau may:

493 a. Notwithstanding the provisions of § 38.2-218, impose a penalty not to exceed \$100,000 per each
494 violation of this subsection;

495 b. Require a carrier to remove a noncompliant nonquantitative treatment limitation, as defined in 42
496 U.S.C. § 300gg-26(a)(8); or

497 c. Require a carrier to revise or otherwise remedy noncompliant portions of a nonquantitative treatment
498 limitation, as defined in 42 U.S.C. § 300gg-26(a)(8).

499 F. The requirements of this section shall apply to all insurance policies and subscription contracts
500 delivered, issued for delivery, reissued, renewed, or extended, or at any time when any term of the policy or
501 contract is changed or any premium adjustment made.

502 F. G. The provisions of this section shall not apply in any instance in which the provisions of this section
503 are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

504 G. The Bureau of Insurance, in consultation with health carriers providing coverage for mental health and
505 substance use disorder benefits pursuant to this section, shall develop reporting requirements regarding
506 denied claims, complaints, appeals, and network adequacy involving such coverage set forth in this section.
507 By November 1, 2027, by December 1 of each odd-numbered year, the Bureau shall compile
508 the information for the preceding year into a report that ensures the confidentiality of individuals whose
509 information has been reported and is written in nontechnical, readily understandable language. The Bureau
510 shall include in the report submit a summary of all comparative analyses prepared by health carriers pursuant
511 to 42 U.S.C. § 300gg-26(a)(8) that the Bureau requested during the reporting period enforcement efforts with
512 respect to the federal Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and state
513 requirements for mental health and substance abuse services and benefits. This summary shall include the
514 Bureau's explanation of whether the analyses were accepted as compliant, rejected as noncompliant, or are in
515 process of review. For analyses that were noncompliant, the report shall include the corrective actions that the
516 Bureau required the health carrier to take to come into compliance any patterns identified in the comparative
517 analyses submitted, supplementary data collected, or market conduct examination or inquiry activities, to the
518 extent that such information can be disclosed. The Bureau shall make the report available to the public by,
519 among such other means as the Bureau finds appropriate, posting the reports on the Bureau's website and
520 submit the report to the Chairs of the House Committee on Labor and Commerce and the Senate Committee
521 on Commerce and Labor.

522 2. That the provisions of subsection A of § 38.2-3412.1 of the Code of Virginia, as amended by this act,
523 shall become effective on July 1, 2027.

524 3. That no later than October 1, 2026, each health carrier subject to the provisions of this act shall
525 submit to the Bureau of Insurance of the State Corporation Commission all comparative analyses
526 prepared by the health carrier pursuant to 42 U.S.C. § 300gg-26(a)(8) and information on how to
527 publicly access such information online.

528 4. That the Board of Health shall promulgate regulations to implement the provisions of this act to be
529 effective within 280 days of its enactment to establish quantitative network adequacy standards for
530 timely access to care, travel time, and geographic distance that are at least as stringent as those
531 imposed by the Virginia Health Benefits Exchange for qualified health plans and qualified dental
532 plans, pursuant to § 32.1-137.3 of the Code of Virginia, as amended by this act.

533 5. That the Department of Human Resource Management (the Department) shall evaluate the impact
534 of the changes to the provisions of subsection A of § 38.2-3412.1 of the Code of Virginia, as amended by
535 this act. In conducting the evaluation, the Department shall consider (i) the potential increase in
536 services and benefits covered by group and individual health insurance as a result of the definitional
537 changes; (ii) the feasibility of compliance with such increase in services and benefits; and (iii) the
538 development of a plan for implementation of the definitional changes, including cost estimates. The
539 Department shall submit a report on its findings to the Chairs of the Senate Committees on Finance
540 and Appropriations and Education and Health and the House Committees on Appropriations and
541 Health and Human Services no later than November 1, 2026.