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SENATE BILL NO. 641

Offered January 23, 2004

A BILL to amend and reenact §§ 2.2-2818, 32.1-325 and 38.2-4319 of the Code of Virginia, as it is currently effective and as it shall become effective, and to amend the Code of Virginia by adding a section numbered 38.2-3418.15, relating to health insurance; coverage for hearing aids for minor children; Medicaid.

Patrons—Ticer, Colgan, Edwards, Houck, Lambert, Lucas, Marsh, Mims, Puller and Whipple

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 32.1-325 and 38.2-4319 of the Code of Virginia, as it is currently effective and as it shall become effective, are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-3418.15 as follows:

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

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

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

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

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

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

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

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

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

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

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

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59 provided incorporating any changes in such Guidelines or Standards within six months of the publication
60 of such Guidelines or Standards or any official amendment thereto.

61 4. Include an appeals process for resolution of written complaints concerning denials or partial
62 denials of claims that shall provide reasonable procedures for resolution of such written complaints and
63 shall be published and disseminated to all covered state employees. The appeals process shall include a
64 separate expedited emergency appeals procedure that shall provide resolution within one business day of
65 receipt of a complaint concerning situations requiring immediate medical care. For appeals involving
66 adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial
67 health entities to review such decisions. Impartial health entities may include medical peer review
68 organizations and independent utilization review companies. The Department shall adopt regulations to
69 assure that the impartial health entity conducting the reviews has adequate standards, credentials and
70 experience for such review. The impartial health entity shall examine the final denial of claims to
71 determine whether the decision is objective, clinically valid, and compatible with established principles
72 of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of
73 fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if
74 consistent with law and policy.

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

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

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

98 6. Include coverage for prescription drugs and devices approved by the United States Food and Drug
99 Administration for use as contraceptives.

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

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

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

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

120 11. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for

annual testing performed by any FDA-approved gynecologic cytology screening technologies.

12. Include coverage providing a minimum stay in the hospital of not less than ~~forty-eight~~ 48 hours for a patient following a radical or modified radical mastectomy and ~~twenty-four~~ 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

13. Include coverage (i) to persons age ~~fifty~~ 50 and over and (ii) to persons age ~~forty~~ 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a ~~twelve~~ 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

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

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

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

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

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

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

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

The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles,

182 copayments and coinsurance factors that are no less favorable than for physical illness generally.

183 For purposes of this subdivision:

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

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

189 "Multiple project assurance contract" means a contract between an institution and the federal
190 Department of Health and Human Services that defines the relationship of the institution to the federal
191 Department of Health and Human Services and sets out the responsibilities of the institution and the
192 procedures that will be used by the institution to protect human subjects.

193 "NCI" means the National Cancer Institute.

194 "NIH" means the National Institutes of Health.

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

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

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

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

- 206 a. The National Cancer Institute;
207 b. An NCI cooperative group or an NCI center;
208 c. The FDA in the form of an investigational new drug application;
209 d. The federal Department of Veterans Affairs; or
210 e. An institutional review board of an institution in the Commonwealth that has a multiple project
211 assurance contract approved by the Office of Protection from Research Risks of the NCI.

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

214 Coverage under this section shall apply only if:

- 215 (1) There is no clearly superior, noninvestigational treatment alternative;
216 (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will
217 be at least as effective as the noninvestigational alternative; and
218 (3) The patient and the physician or health care provider who provides services to the patient under
219 the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to
220 procedures established by the plan.

221 17. Include coverage providing a minimum stay in the hospital of not less than ~~twenty-three~~ 23 hours
222 for a covered employee following a laparoscopy-assisted vaginal hysterectomy and ~~forty-eight~~ 48 hours
223 for a covered employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's
224 nationally recognized guidelines. Nothing in this subdivision shall be construed as requiring the
225 provision of the total hours referenced when the attending physician, in consultation with the covered
226 employee, determines that a shorter hospital stay is appropriate.

227 18. (Effective until July 1, 2004) Include coverage for biologically based mental illness.

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

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

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

In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

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

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

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

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

b. Such coverage shall provide for hearing aids and related services for children from birth to age five on and after July 1, 2004. Such coverage shall include payment of the cost of one hearing aid per hearing-impaired ear every 36 months, up to \$1,400 per hearing aid. The insured may choose a higher-priced hearing aid and may pay the difference in cost above \$1,400, with no financial penalty to the insured or to the provider of the hearing aid. No copayment or fee shall be imposed upon any person receiving benefits pursuant to this section, and no condition may be applied to the person that is not equally imposed upon all individuals in the same benefit category. Coverage shall be available under this section only for services and equipment prescribed by a certified audiologist licensed to prescribe such services or equipment under Chapter 26 (§ 54.1-2600 et seq.) of Title 54.1.

"Hearing aid" means any wearable, nondisposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment.

"Related services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

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

D. For the purposes of this section:

"Peer-reviewed medical literature" means a scientific study published only after having been critically

305 reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal
306 that has been determined by the International Committee of Medical Journal Editors to have met the
307 Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical
308 literature does not include publications or supplements to publications that are sponsored to a significant
309 extent by a pharmaceutical manufacturing company or health carrier.

310 "Standard reference compendia" means the American Medical Association Drug Evaluations, the
311 American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing
312 Information.

313 "State employee" means state employee as defined in § 51.1-124.3, employee as defined in
314 § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301
315 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and
316 domestic relations, and district courts of the Commonwealth, interns and residents employed by the
317 School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of
318 the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

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

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

326 G. The plan shall include, in each planning district, at least two health coverage options, each
327 sponsored by unrelated entities. In each planning district that does not have an available health coverage
328 alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage
329 provider who seeks to provide coverage under the plan. This section shall not apply to any state agency
330 authorized by the Department to establish and administer its own health insurance coverage plan
331 separate from the plan established by the Department.

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

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

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

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

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

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

356 The Ombudsman shall:

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

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

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

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

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

366 6. 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 employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee'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 employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

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

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

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

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

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

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who

428 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per
429 admission;

430 5. A provision for deducting from an institutionalized recipient's income an amount for the
431 maintenance of the individual's spouse at home;

432 6. A provision for payment of medical assistance on behalf of pregnant women which provides for
433 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most
434 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American
435 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards
436 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and
437 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the
438 children which are within the time periods recommended by the attending physicians in accordance with
439 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines
440 or Standards shall include any changes thereto within six months of the publication of such Guidelines
441 or Standards or any official amendment thereto;

442 7. A provision for the payment for family planning services on behalf of women who were
443 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such
444 family planning services shall begin with delivery and continue for a period of 24 months, if the woman
445 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the
446 purposes of this section, family planning services shall not cover payment for abortion services and no
447 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

448 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow
449 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast
450 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a
451 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant.
452 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

453 9. A provision identifying entities approved by the Board to receive applications and to determine
454 eligibility for medical assistance;

455 10. A provision for breast reconstructive surgery following the medically necessary removal of a
456 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been
457 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

458 11. A provision for payment of medical assistance for annual pap smears;

459 12. A provision for payment of medical assistance services for prostheses following the medically
460 necessary complete or partial removal of a breast for any medical reason;

461 13. A provision for payment of medical assistance which provides for payment for 48 hours of
462 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of
463 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for
464 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring
465 the provision of inpatient coverage where the attending physician in consultation with the patient
466 determines that a shorter period of hospital stay is appropriate;

467 14. A requirement that certificates of medical necessity for durable medical equipment and any
468 supporting verifiable documentation shall be signed, dated, and returned by the physician and in the
469 durable medical equipment provider's possession within 60 days from the time the ordered durable
470 medical equipment and supplies are first furnished by the durable medical equipment provider;

471 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons
472 age 40 and over who are at high risk for prostate cancer, according to the most recent published
473 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal
474 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this
475 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate
476 specific antigen;

477 16. A provision for payment of medical assistance for low-dose screening mammograms for
478 determining the presence of occult breast cancer. Such coverage shall make available one screening
479 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
480 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
481 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
482 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
483 radiation exposure of less than one rad mid-breast, two views of each breast;

484 17. A provision, when in compliance with federal law and regulation and approved by the Health
485 Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible
486 students when such services qualify for reimbursement by the Virginia Medicaid program and may be
487 provided by school divisions;

488 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
489 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or

surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss; *Such provision shall include coverage for hearing aids and related services for children from birth to age five on and after July 1, 2004. Such coverage shall include payment of the cost of one hearing aid per hearing-impaired ear every 36 months, up to \$1,400 per hearing aid. The individual may choose a higher-priced hearing aid and may pay the difference in cost above \$1,400, with no financial penalty to the insured or to the provider of the hearing aid. Coverage shall be available under this section only for services and equipment prescribed by a certified audiologist licensed to prescribe such services or equipment under Chapter 26 (§ 54.1-2600 et seq.) of Title 54.1.*

"Hearing aid" means any wearable, nondisposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment.

"Related services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training;

22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women; and

23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for both programs.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with

551 such regulation and, where applicable, sources of potential funds to implement or comply with such
552 regulation.

553 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in
554 accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities
555 With Deficiencies."

556 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or
557 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each
558 recipient of medical assistance services, and shall upon any changes in the required data elements set
559 forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective
560 information as may be required to electronically process a prescription claim.

561 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for
562 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,
563 regardless of any other provision of this chapter, such amendments to the state plan for medical
564 assistance services as may be necessary to conform such plan with amendments to the United States
565 Social Security Act or other relevant federal law and their implementing regulations or constructions of
566 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health
567 and Human Services.

568 In the event conforming amendments to the state plan for medical assistance services are adopted, the
569 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
570 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
571 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
572 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
573 regulations are necessitated by an emergency situation. Any such amendments which are in conflict with
574 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular
575 session of the General Assembly unless enacted into law.

576 D. The Director of Medical Assistance Services is authorized to:

577 1. Administer such state plan and receive and expend federal funds therefor in accordance with
578 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to
579 the performance of the Department's duties and the execution of its powers as provided by law.

580 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other
581 health care providers where necessary to carry out the provisions of such state plan. Any such agreement
582 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is
583 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new
584 agreement or contract. Such provider may also apply to the Director for reconsideration of the
585 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

586 3. Refuse to enter into or renew an agreement or contract with any provider which has been
587 convicted of a felony.

588 4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a
589 principal in a professional or other corporation when such corporation has been convicted of a felony.

590 E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his
591 interest in a convicted professional or other corporation, the Director shall, upon request, conduct a
592 hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's
593 participation in the conduct resulting in the conviction.

594 The Director's decision upon reconsideration shall be consistent with federal and state laws. The
595 Director may consider the nature and extent of any adverse impact the agreement or contract denial or
596 termination may have on the medical care provided to Virginia Medicaid recipients.

597 F. When the services provided for by such plan are services which a clinical psychologist or a
598 clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render
599 in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical
600 social worker or licensed professional counselor or licensed clinical nurse specialist who makes
601 application to be a provider of such services, and thereafter shall pay for covered services as provided in
602 the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists,
603 licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at
604 rates based upon reasonable criteria, including the professional credentials required for licensure.

605 G. The Board shall prepare and submit to the Secretary of the United States Department of Health
606 and Human Services such amendments to the state plan for medical assistance services as may be
607 permitted by federal law to establish a program of family assistance whereby children over the age of 18
608 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of
609 providing medical assistance under the plan to their parents.

610 H. The Department of Medical Assistance Services shall:

611 1. Include in its provider networks and all of its health maintenance organization contracts a
612 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have

special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 38.2-3418.15. Coverage for hearing aids and related services.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for hearing aids and related services for children from birth to age five under any such policy, contract, or plan delivered, issued for delivery or renewed in the Commonwealth on and after July 1, 2004. Such coverage shall include payment of the cost of one hearing aid per hearing-impaired ear every 36 months, up to \$1,400 per hearing aid. The insured may choose a higher-priced hearing aid and may pay the difference in cost above \$1,400, with no financial or contractual penalty to the insured or to the provider of the hearing aid.

B. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment or fee, and no condition may be applied to the person that is not equally imposed upon all individuals in the same benefit category.

C. For the purposes of this section:

"Hearing aid" means any wearable, nondisposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment.

"Related services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

D. Coverage shall be available under this section only for services and equipment prescribed by a certified audiologist licensed to prescribe such services or equipment under Chapter 26 (§ 54.1-2600 et seq.) of Title 54.1.

E. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. (Effective until July 1, 2004) Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 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, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1017 through 38.2-1023, 38.2-1057, Articles 2 (§ 38.2-1306.2 et seq.), 3.1 (§§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.12, 38.2-3418.14, 38.2-3418.15, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and § 38.2-5903 of this title 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.) of this title except with respect to the activities of its health maintenance organization.

B. 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.

C. 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.

D. 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.

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

§ 38.2-4319. (Effective July 1, 2004) Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 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, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1017 through 38.2-1023, 38.2-1057, Articles 2 (§ 38.2-1306.2 et seq.), 3.1 (§§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.12~~, ~~38.2-3418.14~~ 38.2-3418.15, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title 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.) of this title except with respect to the activities of its health maintenance organization.

B. 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.

C. 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.

D. 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.

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