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HOUSE BILL NO. 2482

Offered January 12, 2005

Prefiled January 12, 2005

A BILL to amend and reenact §§ 2.2-2818 and 59.1-200 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 59.1-443.2, relating to restricting the use of social security numbers.

Patron—May

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818 and 59.1-200 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 59.1-443.2 as follows:

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

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

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

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

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

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

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

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

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

2. Include coverage for 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 provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

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

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

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

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

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

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

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

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

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

denial of coverage due to preexisting conditions.

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 48 hours for a patient following a radical or modified radical mastectomy and 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 50 and over and (ii) to persons age 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 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 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 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 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, copayments and coinsurance factors that are no less favorable than for physical illness generally.

For purposes of this subdivision:

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

"FDA" means the Federal Food and Drug Administration.

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

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

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

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

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

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

a. The National Cancer Institute;

b. An NCI cooperative group or an NCI center;

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

d. The federal Department of Veterans Affairs; or

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

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

Coverage under this section shall apply only if:

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

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

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

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

18. Include coverage for biologically based mental illness.

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

Coverage for biologically based mental illnesses shall neither be different nor separate from coverage 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 copayment and coinsurance factors.

Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same

manner as those determinations made for the treatment of any other illness, condition or disorder 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. 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, nurse practitioner or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

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

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

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the

School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

"Part-time state employees" means classified or similarly situated employees in legislative, executive, judicial or independent agencies who are compensated on a salaried basis and work at least 20 hours, but less than 32 hours, per week.

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

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

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

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

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

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

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

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

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

The Ombudsman shall:

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

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

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

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

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

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

O. 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~~*P.* 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 30 days following the death of such state employee.

§ 59.1-200. Prohibited practices.

A. The following fraudulent acts or practices committed by a supplier in connection with a consumer transaction are hereby declared unlawful:

1. Misrepresenting goods or services as those of another;

2. Misrepresenting the source, sponsorship, approval, or certification of goods or services;

3. Misrepresenting the affiliation, connection, or association of the supplier, or of the goods or services, with another;

4. Misrepresenting geographic origin in connection with goods or services;

5. Misrepresenting that goods or services have certain quantities, characteristics, ingredients, uses, or benefits;

6. Misrepresenting that goods or services are of a particular standard, quality, grade, style, or model;

7. Advertising or offering for sale goods that are used, secondhand, repossessed, defective, blemished, deteriorated, or reconditioned, or that are "seconds," irregulars, imperfects, or "not first class," without clearly and unequivocally indicating in the advertisement or offer for sale that the goods are used, secondhand, repossessed, defective, blemished, deteriorated, reconditioned, or are "seconds," irregulars, imperfects or "not first class";

8. Advertising goods or services with intent not to sell them as advertised, or with intent not to sell at the price or upon the terms advertised.

In any action brought under this subdivision, the refusal by any person, or any employee, agent, or servant thereof, to sell any goods or services advertised or offered for sale at the price or upon the terms advertised or offered, shall be prima facie evidence of a violation of this subdivision. This paragraph shall not apply when it is clearly and conspicuously stated in the advertisement or offer by which such goods or services are advertised or offered for sale, that the supplier or offeror has a limited quantity or amount of such goods or services for sale, and the supplier or offeror at the time of such advertisement or offer did in fact have or reasonably expected to have at least such quantity or amount for sale;

9. Making false or misleading statements of fact concerning the reasons for, existence of, or amounts of price reductions;

10. Misrepresenting that repairs, alterations, modifications, or services have been performed or parts installed;

11. Misrepresenting by the use of any written or documentary material that appears to be an invoice or bill for merchandise or services previously ordered;

12. Notwithstanding any other provision of law, using in any manner the words "wholesale," "wholesaler," "factory," or "manufacturer" in the supplier's name, or to describe the nature of the supplier's business, unless the supplier is actually engaged primarily in selling at wholesale or in manufacturing the goods or services advertised or offered for sale;

13. Using in any contract or lease any liquidated damage clause, penalty clause, or waiver of defense, or attempting to collect any liquidated damages or penalties under any clause, waiver, damages, or penalties that are void or unenforceable under any otherwise applicable laws of the Commonwealth, or under federal statutes or regulations;

14. Using any other deception, fraud, false pretense, false promise, or misrepresentation in connection with a consumer transaction;

15. Violating any provision of §§ 3.1-796.78, 3.1-796.79, or § 3.1-796.82, relating to the sale of certain animals by pet dealers which is described in such sections, is a violation of this chapter;

16. Failing to disclose all conditions, charges, or fees relating to:

a. The return of goods for refund, exchange, or credit. Such disclosure shall be by means of a sign attached to the goods, or placed in a conspicuous public area of the premises of the supplier, so as to be readily noticeable and readable by the person obtaining the goods from the supplier. If the supplier does not permit a refund, exchange, or credit for return, he shall so state on a similar sign. The provisions of this subdivision shall not apply to any retail merchant who has a policy of providing, for a period of not less than 20 days after date of purchase, a cash refund or credit to the purchaser's credit card account for the return of defective, unused, or undamaged merchandise upon presentation of proof of purchase. In the case of merchandise paid for by check, the purchase shall be treated as a cash purchase and any refund may be delayed for a period of 10 banking days to allow for the check to clear. This subdivision does not apply to sale merchandise that is obviously distressed, out of date, post season, or otherwise reduced for clearance; nor does this subdivision apply to special order purchases where the purchaser has requested the supplier to order merchandise of a specific or unusual size, color, or brand not ordinarily carried in the store or the store's catalog; nor shall this subdivision apply in connection with a transaction for the sale or lease of motor vehicles, farm tractors, or motorcycles as defined in § 46.2-100;

b. A layaway agreement. Such disclosure shall be furnished to the consumer (i) in writing at the time of the layaway agreement, or (ii) by means of a sign placed in a conspicuous public area of the premises of the supplier, so as to be readily noticeable and readable by the consumer, or (iii) on the bill of sale. Disclosure shall include the conditions, charges, or fees in the event that a consumer breaches the agreement;

16a. Failing to provide written notice to a consumer of an existing open-end credit balance in excess of $5 (i) on an account maintained by the supplier and (ii) resulting from such consumer's overpayment on such account. Suppliers shall give consumers written notice of such credit balances within 60 days of receiving overpayments. If the credit balance information is incorporated into statements of account furnished consumers by suppliers within such 60-day period, no separate or additional notice is required;

17. If a supplier enters into a written agreement with a consumer to resolve a dispute that arises in connection with a consumer transaction, failing to adhere to the terms and conditions of such an agreement;

18. Violating any provision of the Virginia Health Spa Act, Chapter 24 (§ 59.1-294 et seq.) of this title;

19. Violating any provision of the Virginia Home Solicitation Sales Act, Chapter 2.1 (§ 59.1-21.1 et seq.) of this title;

20. Violating any provision of the Automobile Repair Facilities Act, Chapter 17.1 (§ 59.1-207.1 et seq.) of this title;

21. Violating any provision of the Virginia Lease-Purchase Agreement Act, Chapter 17.4 (§ 59.1-207.17 et seq.) of this title;

22. Violating any provision of the Prizes and Gifts Act, Chapter 31 (§ 59.1-415 et seq.) of this title;

23. Violating any provision of the Virginia Public Telephone Information Act, Chapter 32 (§ 59.1-424 et seq.) of this title;

24. Violating any provision of § 54.1-1505;

25. Violating any provision of the Motor Vehicle Manufacturers' Warranty Adjustment Act, Chapter 17.6 (§ 59.1-207.34 et seq.) of this title;

26. Violating any provision of § 3.1-949.1, relating to the pricing of merchandise;

27. Violating any provision of the Pay-Per-Call Services Act, Chapter 33 (§ 59.1-429 et seq.) of this title;

28. Violating any provision of the Extended Service Contract Act, Chapter 34 (§ 59.1-435 et seq.) of this title;

29. Violating any provision of the Virginia Membership Camping Act, Chapter 25 (§ 59.1-311 et seq.) of this title;

30. Violating any provision of the Comparison Price Advertising Act, Chapter 17.7 (§ 59.1-207.40 et seq.) of this title;

31. Violating any provision of the Virginia Travel Club Act, Chapter 36 (§ 59.1-445 et seq.) of this title;

32. Violating any provision of §§ 46.2-1231 and 46.2-1233.1;
33. Violating any provision of Chapter 40 (§ 54.1-4000 et seq.) of Title 54.1;
34. Violating any provision of Chapter 10.1 (§ 58.1-1031 et seq.) of Title 58.1;
35. Using the consumer's social security number as the consumer's account number with the supplier, if the consumer has *(i) requested that his control number issued by the Department of Motor Vehicles pursuant to § 46.2-342 be used or (ii)* requested in writing that the supplier use an alternate number not associated with the consumer's social security number;
36. Violating any provision of Chapter 18 (§ 6.1-444 et seq.) of Title 6.1;
37. Violating any provision of § 8.01-40.2;
38. Violating any provision of Article 7 (§ 32.1-212 et seq.) of Chapter 6 of Title 32.1;
39. Violating any provision of Chapter 34.1 (§ 59.1-441.1 et seq.) of this title;
40. Violating any provision of Chapter 10.2 (§ 6.1-363.2 et seq.) of Title 6.1; ~~and~~
41. Violating any provision of the Virginia Post-Disaster Anti-Price Gouging Act, Chapter 46 (§ 59.1-525 et seq.) of this title*; and*
42. Violating any provision of the Personal Information Privacy Act, Chapter 35 (§ 59.1-442 et seq.) of this title.

B. Nothing in this section shall be construed to invalidate or make unenforceable any contract or lease solely by reason of the failure of such contract or lease to comply with any other law of the Commonwealth or any federal statute or regulation, to the extent such other law, statute, or regulation provides that a violation of such law, statute, or regulation shall not invalidate or make unenforceable such contract or lease.

§ 59.1-443.2. Restricted use of social security numbers.

A. Except as otherwise specifically provided by law, a person shall not:

1. Intentionally communicate an individual's social security number to the general public;

2. Print an individual's social security number on any card required for the individual to access or receive products or services provided by the person or entity;

3. Require an individual to use his social security number to access an Internet website, unless a password or unique personal identification number or other authentication device is also required to access the site; or

4. Send or cause to be sent or delivered any letter, envelope, or package that displays a social security number on the face of the mailing envelope or package, or from which a social security number is visible, whether on the outside or inside of the mailing envelope or package.

B. Notwithstanding subsection A, a person who, before July 1, 2005, used an individual's social security number in a manner inconsistent with subsection A may continue using that individual's social security number in that manner on and after July 1, 2005, subject to the following conditions:

1. The use of the social security number must be continuous. If the use is stopped for any reason, subsection A applies.

2. Beginning July 1, 2005, the person must provide the individual with an annual written disclosure of the individual's right to stop the use of the social security number in a manner prohibited by subsection A.

3. If the individual requests in writing, the person must stop using the social security number in a manner prohibited by subsection A within 30 days after receiving the request. No fee or charge is allowed for implementing the request, and the person shall not deny services to the individual because of the request.

C. This section does not prohibit the collection, use, or release of a social security number as permitted by the laws of the Commonwealth or the United States, or the use of a social security number for internal verification or administrative purposes unless such use is prohibited by a state or federal statute, rule, or regulation.

D. In the case of a health care service plan, a provider of health care, an insurer, a pharmacy benefits manager, or a contractor, the requirements of subdivision A 2 shall become operative on January 1, 2006, and the requirements of subsection B shall not apply.

E. This section shall not apply to public bodies as that term is defined in § 2.2-3701.

This section shall not apply to records required by law to be open to the public, nor shall it be construed to limit access to records pursuant to the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

F. A person may not embed an encrypted or unencrypted social security number in or on a card or document, including, but not limited to, using a bar code, chip, magnetic strip, or other technology, in place of removing the social security number as required by this section.