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HOUSE BILL NO. 253

Offered January 9, 2008

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A BILL to amend and reenact §§ 2.2-2503, 2.2-2504, 2.2-2664, 2.2-5300, 12.1-16, 32.1-137.1, 32.1-137.2, 32.1-137.3, 32.1-137.5, 32.1-137.6, 32.1-137.15, 32.1-330.3, 32.1-335, 38.2-100, 38.2-229, 38.2-305, 38.2-400, and 54.1-2909 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-200.1, relating to the establishment of a Bureau of Health Insurance and position of Health Insurance Commissioner within the State Corporation Commission.

Patron—O'Bannon

Referred to Committee on General Laws

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2503, 2.2-2504, 2.2-2664, 2.2-5300, 12.1-16, 32.1-137.1, 32.1-137.2, 32.1-137.3, 32.1-137.5, 32.1-137.6, 32.1-137.15, 32.1-330.3, 32.1-335, 38.2-100, 38.2-229, 38.2-305, 38.2-400, and 54.1-2909 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-200.1 as follows:

§ 2.2-2503. Special Advisory Commission on Mandated Health Insurance Benefits; membership; terms; meetings; compensation and expenses; staff; chairman's executive summary.

A. The Special Advisory Commission on Mandated Health Insurance Benefits (the Commission) is established as an advisory commission within the meaning of § 2.2-2100, in the executive branch of state government. The purpose of the Commission shall be to advise the Governor and the General Assembly on the social and financial impact of current and proposed mandated benefits and providers, in the manner set forth in this article.

B. The Commission shall consist of 18 members that include six legislative members, 10 nonlegislative citizen members, and two ex officio members as follows: one member of the Senate Committee on Education and Health and one member of the Senate Committee on Commerce and Labor appointed by the Senate Committee on Rules; two members of the House Committee on Health, Welfare and Institutions and two members of the House Committee on Commerce and Labor appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; 10 nonlegislative citizen members appointed by the Governor that include one physician, one chief executive officer of a general acute care hospital, one allied health professional, one representative of small business, one representative of a major industry, one expert in the field of medical ethics, two representatives of the accident and health insurance industry, and two nonlegislative citizen members; and the State Commissioner of Health and the ~~State~~ *Health Insurance* Commissioner ~~of Insurance~~, or their designees, who shall serve as ex officio nonvoting members.

C. All nonlegislative citizen members shall be appointed for terms of four years. Legislative and ex officio members shall serve terms coincident with their terms of office. All members may be reappointed. However, no House member shall serve more than four consecutive two-year terms, no Senate member shall serve more than two consecutive four-year terms, and no nonlegislative citizen member shall serve more than two consecutive four-year terms. Vacancies occurring other than by expiration of a term shall be filled for the unexpired term. Vacancies shall be filled in the manner as the original appointments. The remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's eligibility for reappointment.

D. The Commission shall meet at the request of the chairman, the majority of the voting members or the Governor. The Commission shall elect a chairman and a vice-chairman, as determined by the membership. A majority of the members of the Commission shall constitute a quorum.

E. Legislative members of the Commission shall receive such compensation as provided in § 30-19.12, and nonlegislative citizen members shall receive such compensation for the performance of their duties as provided in § 2.2-2813. All members shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the compensation and costs of expenses of the members shall be provided by the State Corporation Commission.

F. The Bureau of *Health* Insurance, the State Health Department, and the Joint Legislative Audit and Review Commission and such other state agencies as may be considered appropriate by the Commission shall provide staff assistance to the Commission. The Joint Legislative Audit and Review Commission

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shall conduct assessments, analyses, and evaluations of proposed mandated health insurance benefits and mandated providers as provided in subsection D of § 30-58.1, and report its findings with respect to the proposed mandates to the Commission.

G. The chairman of the Commission shall submit to the Governor and the General Assembly an annual executive summary of the interim activity and work of the Commission no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

§ 2.2-2504. Duties of the Commission.

The Special Advisory Commission shall:

1. Develop and maintain, with the Bureau of *Health* Insurance, a system and program of data collection to assess the impact of mandated benefits and providers, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers and other data as may be appropriate.

2. Advise and assist the Bureau of *Health* Insurance on matters relating to mandated insurance benefits and provider regulations.

3. Prescribe the format, content, and timing of information to be submitted to it in its assessment of proposed and existing mandated benefits and providers. Such format, content, and timing requirements shall be binding upon all parties submitting information to the Commission in its assessment of proposed and existing mandated benefits and providers.

4. Provide assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the General Assembly.

5. Provide additional information and recommendations, relating to any system of mandated health insurance benefits and providers, to the Governor and the General Assembly upon request.

6. Report annually on its activities to the joint standing committees of the General Assembly having jurisdiction over insurance by December 1 of each year.

7. Review and evaluate as necessary the benefits and other provisions of the essential and standard health benefits plans established pursuant to § 38.2-3431, and submit to the State Corporation Commission, for adoption in the State Corporation Commission's applicable regulations pursuant to § 38.2-3431, any modifications needed to maintain or enhance the affordability and marketability of the plans.

§ 2.2-2664. Virginia Interagency Coordinating Council; purpose; membership; duties.

A. The Virginia Interagency Coordinating Council (the Council) is established as an advisory council, within the meaning of § 2.2-2100, in the executive branch of state government. The purpose of the Council shall be to promote and coordinate early intervention services in the Commonwealth.

B. The membership and operation of the Council shall be as required by Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.). The Commissioner of the Department of Health, the Director of the Department for the Deaf and Hard-of-Hearing, the Superintendent of Public Instruction, the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Social Services, the Commissioner of the Department for the Blind and Vision Impaired, the Director of the Virginia Office for Protection and Advocacy, and the *Health Insurance* Commissioner ~~of the Bureau of Insurance~~ within the State Corporation Commission shall each appoint one person from his agency to serve as the agency's representative on the Council.

Agency representatives shall regularly inform their agency head of the Council's activities and the status of the implementation of an early intervention services system in the Commonwealth.

C. The Council's duties shall include advising and assisting the state lead agency in the following:

1. Performing its responsibilities for the early intervention services system;

2. Identifying sources of fiscal and other support for early intervention services, recommending financial responsibility arrangements among agencies, and promoting interagency agreements;

3. Developing strategies to encourage full participation, coordination, and cooperation of all appropriate agencies;

4. Resolving interagency disputes;

5. Gathering information about problems that impede timely and effective service delivery and taking steps to ensure that any identified policy problems are resolved;

6. Preparing federal grant applications; and

7. Preparing and submitting an annual report to the Governor and the U.S. Secretary of Education on the status of early intervention services within the Commonwealth.

§ 2.2-5300. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Council" means the Virginia Interagency Coordinating Council created pursuant to § 2.2-2664.

"Early intervention services" means services provided through Part C of the Individuals with

Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a 25 percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Early intervention services provided in the child's home and in accordance with this chapter shall not be construed to be home health services as referenced in § 32.1-162.7.

"Participating agencies" means the Departments of Health, of Education, of Medical Assistance Services, of Mental Health, Mental Retardation and Substance Abuse Services, and of Social Services; the Departments for the Deaf and Hard-of-Hearing and for the Blind and Vision Impaired; the Virginia Office for Protection and Advocacy; and the Bureau of *Health* Insurance within the State Corporation Commission.

§ 12.1-16. Delegation to employees and agents; Commissioner of Financial Institutions, Commissioner of Insurance, and Health Insurance Commissioner.

In the exercise of the powers and in the performance of the duties imposed by law upon the Commission with respect to insurance and banking, the Commission may delegate to such employees and agents as it may deem proper such powers and require of them, or any of them, the performance of such duties as it may deem proper. The employee or agent who is placed by the Commission at the head of the bureau ~~or division~~ through which it administers the banking laws shall be designated "Commissioner of Financial Institutions~~,~~." ~~and the~~*The* employee or agent who is placed by the Commission at the head of the bureau ~~or division~~ through which it administers the insurance laws, *other than laws pertaining to health insurance,* shall be designated "Commissioner of Insurance~~,~~." ~~and they~~ *The employee or agent who is placed by the Commission at the head of the division through which it administers the health insurance laws shall be designated "Health Insurance Commissioner." They* and all deputies, agents, and employees used in such bureau or division shall be appointed by the Commission.

§ 32.1-137.1. Definitions.

As used in this and the following article, unless the context indicates otherwise:

"Agent" or "insurance agent," when used without qualification, means an individual, partnership, limited liability company, or corporation that solicits, negotiates, procures or effects contracts of insurance or annuity in this Commonwealth.

"Bureau of *Health* Insurance" means the State Corporation Commission acting pursuant to Title 38.2.

"Complaint" means any written communication from a covered person primarily expressing a grievance.

"Covered person" means an individual residing in the Commonwealth, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan under Title 38.2.

"Managed care health insurance plan" means an arrangement for the delivery of health care in which a health carrier as defined in § 38.2-5800 undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more managed care health insurance plans. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Managed care health insurance plan licensee" means a health carrier subject to licensure by the Bureau of *Health* Insurance under Title 38.2 who is responsible for a managed care health insurance plan in accordance with Chapter 58 (§ 38.2-5801 et seq.) of Title 38.2.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, other organization, partnership, receiver, reciprocal or inter-insurance exchange, trustee or society.

§ 32.1-137.2. Certification of quality assurance; application; issuance; denial; renewal.

A. Every managed care health insurance plan licensee shall request a certificate of quality assurance with reference to its managed care health insurance plans simultaneously with filing an initial application to the Bureau of Insurance for licensure. If already licensed by the Bureau of *Health* Insurance, every managed care health insurance plan licensee may file an application for quality assurance certification with the Department of Health by December 1, 1998, and shall file an application for quality assurance certification with the Department of Health by December 1, 1999, in order to obtain its certificate of quality assurance by July 1, 2000.

On or before July 1, 2000, the State Health Commissioner shall certify to the Bureau of *Health* Insurance that a managed care health insurance plan licensee has been issued a certificate of quality assurance by providing the Bureau of *Health* Insurance with a copy of each certificate at the time of issuance.

Application for a certificate of quality assurance shall be made on a form prescribed by the Board and shall be accompanied by a fee based upon a percentage, not to exceed one-tenth of one percent, of the proportion of direct gross premium income on business done in this Commonwealth attributable to the operation of managed care health insurance plans in the preceding biennium, sufficient to cover reasonable costs for the administration of the quality assurance program. Such fee shall not exceed $10,000 per licensee. Whenever the account of the program shows expenses for the past biennium to be more than ten percent greater or lesser than the funds collected, the Board shall revise the fees levied by it for certification so that the fees are sufficient, but not excessive, to cover expenses; provided that such fees shall not exceed the limits set forth in this section.

All applications, including those for renewal, shall require (i) a description of the geographic area to be served, with a map clearly delineating the boundaries of the service area or areas, (ii) a description of the complaint system required under § 32.1-137.6, (iii) a description of the procedures and programs established by the licensee to assure both availability and accessibility of adequate personnel and facilities and to assess the quality of health care services provided, and (iv) a list of the licensee's managed care health insurance plans.

B. Every managed care health insurance plan licensee certified under this article shall renew its certificate of quality assurance with the Commissioner biennially by July 1, subject to payment of the fee.

C. The Commissioner shall periodically examine or review each applicant for certificate of quality assurance or for renewal thereof.

No certificate of quality assurance may be issued or renewed unless a managed care health insurance plan licensee has filed a completed application and made payment of a fee pursuant to subsection A of this section and the Commissioner is satisfied, based upon his examination, that, to the extent appropriate for the type of managed care health insurance plan under examination, the managed care health insurance plan licensee has in place and complies with: (i) a complaint system for reasonable and adequate procedures for the timely resolution of written complaints pursuant to § 32.1-137.6; (ii) a reasonable and adequate system for assessing the satisfaction of its covered persons; (iii) a system to provide for reasonable and adequate availability of and accessibility to health care services for its covered persons; (iv) reasonable and adequate policies and procedures to encourage the appropriate provision and use of preventive services for its covered persons; (v) reasonable and adequate standards and procedures for credentialing and recredentialing the providers with whom it contracts; (vi) reasonable and adequate procedures to inform its covered persons and providers of the managed care health insurance plan licensee's policies and procedures; (vii) reasonable and adequate systems to assess, measure, and improve the health status of covered persons, including outcome measures, (viii) reasonable and adequate policies and procedures to ensure confidentiality of medical records and patient information to permit effective and confidential patient care and quality review; (ix) reasonable, timely and adequate requirements and standards pursuant to § 32.1-137.9; and (x) such other requirements as the Board may establish by regulation consistent with this article.

Upon the issuance or reissuance of a certificate, the Commissioner shall provide a copy of such certificate to the Bureau of *Health* Insurance.

D. Upon determining to deny a certificate, the Commissioner shall notify such applicant in writing stating the reasons for the denial of a certificate. A copy of such notification of denial shall be provided to the Bureau of *Health* Insurance. Appeals from a notification of denial shall be brought by a certificate applicant pursuant to the process set forth in § 32.1-137.5.

E. The State Corporation Commission shall give notice to the Commissioner of its intention to issue an order based upon a finding of insolvency, hazardous financial condition, or impairment of net worth or surplus to policyholders or an order suspending or revoking the license of a managed care health insurance plan licensee; and the Commissioner shall notify the Bureau of *Health* Insurance when he has reasonable cause to believe that a recommendation for the suspension or revocation of a certificate of quality assurance or the denial or nonrenewal of such a certificate may be made pursuant to this article. Such notifications shall be privileged and confidential and shall not be subject to subpoena.

F. No certificate of quality assurance issued pursuant to this article may be transferred or assigned without approval of the Commissioner.

§ 32.1-137.3. Regulations.

Consistent with its duties to protect the health, safety, and welfare of the public, the Board shall promulgate regulations, consistent with this article, governing the quality of care provided to covered persons by a managed care health insurance plan licensee through its managed care health insurance plans on or before December 1, 1999. The regulations may incorporate or apply nationally recognized, generally accepted, quality standards developed by private accreditation entities, if such standards exist and as appropriate for the type of managed care health insurance plan. The regulations shall also include guidelines for the Commissioner to determine, in consultation with the Bureau of *Health* Insurance, when the imposition of administrative sanctions as set forth in § 32.1-137.5 or initiation of court proceedings or both are appropriate in order to ensure prompt correction of violations discovered on any examination, review, or investigation conducted by the Department pursuant to provisions of this article.

§ 32.1-137.5. Civil penalties; probation; suspension; restriction or prohibition of new enrollments to managed care health insurance plan licensee; revocation or nonrenewal of certificate of quality assurance; appeal process; correction.

A. In accordance with applicable regulations of the Board and in consultation with the Bureau of *Health* Insurance, the Commissioner (i) may impose civil penalties, which shall not exceed $1,000 per incident of noncompliance, to a maximum of $10,000 for a series of related incidents of noncompliance, (ii) may place a certificate holder on probation, (iii) may temporarily suspend a certificate of quality assurance of a managed care health insurance plan licensee, (iv) may, with the concurrence of the Bureau of Insurance, temporarily restrict or prohibit new enrollments into a managed care health insurance plan, or (v) may revoke or not renew a certificate of quality assurance and certify to the State Corporation Commission that a managed care health insurance plan licensee or its managed care health insurance plan is unable to fulfill its obligations to furnish quality health care services as set forth in this article. Fines payable under this section shall be paid into the Literary Fund.

B. When examination or review or complaint investigation by the Department results in a finding of noncompliance with the provisions of this article or the regulations of the Board, the managed care health insurance plan licensee or applicant shall be provided written notice and a report specifying the findings of noncompliance and providing an opportunity to be heard in no fewer than ~~thirty~~ *30* days by the Commissioner's adjudication officer in a proceeding under § 2.2-4019. A copy of the notice and report shall be provided to the Bureau of *Health* Insurance. Such proceeding shall be separate from the regulatory office of the Department that conducted the examination, review, or investigation and shall be closed and confidential. The records of the proceedings shall be privileged and confidential and shall not be subject to subpoena.

The adjudication officer shall provide a recommendation to the Commissioner, including findings of fact, conclusions, and appropriate disciplinary action or sanction. The Commissioner shall promptly notify the Bureau of *Health* Insurance if the recommended disciplinary action or sanction proposes probation, suspension, nonrenewal, or revocation of a certificate of quality assurance, or the temporary restriction or prohibition of new enrollments in a managed care health insurance plan. The Commissioner may affirm, modify, or reverse such recommendation and shall issue a final decision.

The Commissioner's decision may be appealed directly to a circuit court under Article 4 (§ 2.2-4025 et seq.) of the Administrative Process Act. The only parties to the case shall be the managed care health insurance plan licensee and the Department. The Commissioner shall promptly notify the Bureau of *Health* Insurance of the commencement and final determination of an appeals proceeding.

C. If a certificate of quality assurance has been revoked or suspended or a certificate holder has been placed on probation, a new certificate may be issued or the suspension may be terminated or the probation removed by the Commissioner after satisfactory evidence is submitted to him that the conditions upon which revocation, suspension, or probation was based have been corrected and after proper examination has been made and compliance with all provisions of this article and the regulations of the Board has been shown.

§ 32.1-137.6. Complaint system.

A. Each managed care health insurance plan licensee subject to § 32.1-137.2 shall establish and maintain for each of its managed care health insurance plans a complaint system approved by the Commissioner and the Bureau of *Health* Insurance to provide reasonable procedures for the resolution of written complaints in accordance with the requirements established under this article and Title 38.2, and shall include the following:

1. A record of the complaints shall be maintained for the period set forth in § 32.1-137.16 for review by the Commissioner.

2. Each managed care health insurance plan licensee shall provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or

procedures shall include the address and telephone number of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and the electronic mail address of the Office of the Managed Care Ombudsman established pursuant to § 38.2-5904 and shall also specify any required limits imposed by or on behalf of the managed care health insurance plan. Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions pursuant to § 32.1-137.15.

B. The Commissioner, in cooperation with the Bureau of *Health* Insurance, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this article shall be assessed by the State Health Commissioner under this article. Compliance by the health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of Title 38.2, shall be assessed by the Bureau of *Health* Insurance.

C. As part of the renewal of a certificate, each managed care health insurance plan licensee shall submit to the Commissioner and to the Office of the Managed Care Ombudsman an annual complaint report in a form agreed and prescribed by the Board and the Bureau of *Health* Insurance. The complaint report shall include, but shall not be limited to (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the managed care health insurance plan's health care providers.

The Department of Human Resource Management and the Department of Medical Assistance Services shall file similar periodic reports with the Commissioner, in a form prescribed by the Board, providing appropriate information on all complaints received concerning quality of care and utilization review under their respective health benefits program and managed care health insurance plan licensee contractors.

D. The Commissioner shall examine the complaint system under subsection B for compliance of the complaint system with respect to quality of care and shall require corrections or modifications as deemed necessary.

E. The Commissioner shall have no jurisdiction to adjudicate individual controversies arising under this article.

F. The Commissioner of Health or the nonprofit organization pursuant to § 32.1-276.4 may prepare a summary of the information submitted pursuant to this provision and § 32.1-122.10:01 to be included in the patient level data base.

§ 32.1-137.15. Final adverse decision; appeal.

A. Each entity shall establish an appeals process, including a process for expedited appeals, to consider any final adverse decision that is appealed by a covered person, his representative, or his provider. Except as provided in subsection E, notification of the results of the appeal process shall be provided to the appellant no later than sixty working days after receiving the required documentation. The decision shall be in writing and shall state the criteria used and the clinical reason for the decision. If the appeal is denied, such notification shall include a clear and understandable description of the covered person's right to appeal final adverse decisions to the Bureau of *Health* Insurance in accordance with Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2, the procedures for making such an appeal, and the binding nature and effect of such an appeal, including all forms prescribed by the Bureau of *Health* Insurance pursuant to § 38.2-5901. Such notification shall also include the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman. Further, such notification shall advise any such covered person that, except in the instance of fraud, any such appeal herein may preclude such person's exercise of any other right or remedy relating to such adverse decision. An expedited appeals process of no more than ~~twenty-four~~ *24* hours shall be established and conducted by telephone to consider any final adverse decision that relates to a prescription to alleviate cancer pain.

B. Any case under appeal shall be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal shall be a peer of the treating health care provider, shall be board certified or board eligible, and shall be specialized in a discipline pertinent to the issue under review.

A physician advisor or peer of the treating health care provider who renders a decision on appeal shall (i) not have participated in the adverse decision or any prior reconsideration thereof; (ii) not be employed by or a director of the utilization review entity; and (iii) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

C. The utilization review entity shall provide an opportunity for the appellant to present additional evidence for consideration on appeal. Before rendering an adverse appeal decision, the utilization review entity shall review the pertinent medical records of the covered person's provider and the pertinent records of any facility in which health care is provided to the covered person which have been furnished to the entity.

D. In the appeals process, due consideration shall be given to the availability or nonavailability of alternative health care services proposed by the entity. No provision herein shall prevent an entity from considering any hardship imposed by the alternative health care on the patient and his immediate family.

E. When an adverse decision or adverse reconsideration is made and the treating health care provider believes that the decision warrants an immediate appeal, the treating health care provider shall have the opportunity to appeal the adverse decision or adverse reconsideration by telephone on an expedited basis. The treating health care provider shall have the opportunity to appeal immediately, by telephone, on an expedited basis, an adverse decision or adverse reconsideration relating to a prescription to alleviate cancer pain.

The decision on an expedited appeal shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor on the panel.

The utilization review entity shall decide the expedited appeal no later than one business day after receipt by the entity of all necessary information.

An expedited appeal may be requested only when the regular reconsideration and appeals process will delay the rendering of health care in a manner that would be detrimental to the health of the patient or would subject the cancer patient to pain. Both providers and utilization review entities shall attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the expedited appeal in a satisfactory manner.

An expedited appeal decision may be further appealed through the standard appeal process established by the entity unless all material information and documentation were reasonably available to the provider and to the entity at the time of the expedited appeal, and the physician advisor reviewing the case under expedited appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline pertinent to the issue under review.

F. The appeals process required by this section does not apply to any adverse decision, reconsideration, or final adverse decision rendered solely on the basis that a health benefit plan does not provide benefits for the health care rendered or requested to be rendered.

G. No entity performing utilization review pursuant to this article or Article 2.1 (§ 32.1-138.6 et seq.) of Chapter 5 of this title, shall terminate the employment or other contractual relationship or otherwise penalize a health care provider for advocating the interest of his patient or patients in the appeals process or invoking the appeals process, unless the provider engages in a pattern of filing appeals that are without merit.

§ 32.1-330.3. Operation of a pre-PACE plan or PACE plan; oversight by Department of Medical Assistance Services.

A. Operation of a pre-PACE plan or PACE plan that participates in the medical assistance services program must be in accordance with a prepaid health plan contract or other PACE contract consistent with Chapter 6 of Title IV of the federal Balanced Budget Act of 1997 with the Department of Medical Assistance Services.

1. As used in this section, "pre-PACE" means of or associated with long-term care prepaid health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act (42 U.S.C. § 1396b et seq.) and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of this title and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

2. As used in this section, "PACE" means of or associated with long-term care health plans (i) authorized as programs of all-inclusive care for the elderly by Subtitle I (§ 4801 et seq.) of Chapter 6 of Title IV of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 528 et seq., §§ 4801-4804, 1997, pursuant to Title XVIII and Title XIX of the United States Social Security Act (42 U.S.C. § 1395eee et seq.), and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of this title and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

B. All contracts and subcontracts shall contain an agreement to hold harmless the Department of Medical Assistance Services and pre-PACE and PACE enrollees in the event that a pre-PACE or PACE provider cannot or will not pay for services performed by the subcontractor pursuant to the contract or subcontract.

C. During the pre-PACE or PACE period, the plan shall have a fiscally sound operation as

demonstrated by total assets being greater than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due, and a plan for handling insolvency approved by the Department of Medical Assistance Services.

D. The pre-PACE or PACE plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event of insolvency:

1. One month's total capitation revenue to cover expenses the month prior to insolvency; and

2. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

The required arrangements to cover expenses shall be in accordance with the PACE Protocol as published by On Lok, Inc. in cooperation with the United States Health Care Financing Administration, as of April 14, 1995, or any successor protocol that may be agreed upon between the United States Health Care Financing Administration and On Lok, Inc.

Appropriate arrangements to cover expenses shall include one or more of the following: reasonable and sufficient net worth, insolvency insurance, letters of credit or parental guarantees.

E. Enrollment in a pre-PACE or PACE plan shall be restricted to those individuals who participate in programs authorized pursuant to Title XIX or Title XVIII of the United States Social Security Act, respectively.

F. Full disclosure shall be made to all individuals in the process of enrolling in the pre-PACE or PACE plan that services are not guaranteed beyond a thirty-day period.

G. The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license requirements, regulations and ongoing oversight. The Advisory Group shall include representatives from each of the following organizations: Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of *Health* Insurance, Board of Medicine, Board of Pharmacy, Department for the Aging, and a pre-PACE or PACE provider.

§ 32.1-335. Technical Advisory Panel.

The Board shall annually appoint a Technical Advisory Panel whose duties shall include recommending to the Board (i) policy and procedures for administration of the fund, (ii) methodology relating to creation of charity care standards, eligibility and service verification, and (iii) contribution rates and distribution of payments. The Panel shall also advise the Board on any matters relating to the governance or administration of the fund as may from time to time be appropriate and on the establishment of pilot health care projects for the uninsured. In addition to these duties, the Panel shall, in accordance with Board regulations, establish pilot health care projects for the uninsured and shall administer any money voluntarily contributed or donated to the fund by private or public sources, including local governments, for the purpose of subsidizing pilot health care projects for the uninsured.

The Panel shall consist of fifteen members as follows: the Chairman of the Board, the Director of the Department of Medical Assistance Services, the Commissioner of Health, the *Health Insurance* Commissioner ~~of the Bureau of Insurance~~ or his designee, the chairman of the Virginia Health Care Foundation or his designee, two additional members of the Board, one of whom shall be the representative of the hospital industry, and two chief executive officers of hospitals as nominated by the Virginia Hospital and Healthcare Association.

In addition, there shall be three representatives of private enterprise who shall be executives serving in business or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the business and industry community in Virginia including, but not limited to, the Virginia Manufacturers Association, the Virginia Chamber of Commerce, the Virginia Retail Merchants Association, and the Virginia Small Business Advisory Board. There shall be two representatives from the insurance industry who shall be executives serving in insurance companies or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the insurance industry in Virginia including, but not limited to, Blue Cross/Blue Shield of Virginia, Health Insurance Association of America and the Virginia Association of Health Maintenance Organizations. There shall be one physician member. Nominations for this appointment may be submitted to the Board by associations representing medical professionals, including, but not limited to, the Medical Society of Virginia and the Old Dominion Medical Society.

§ 38.2-100. Definitions.

As used in this title:

"Alien company" means a company incorporated or organized under the laws of any country other than the United States.

"Commission" means the State Corporation Commission.

"Commissioner" or "Commissioner of Insurance" ~~means~~*:*

1. When used in Chapters 10 through 33, 37 through 41, 44 through 55, and 59 through 62 of this title means the administrative or executive officer of the division or bureau of the Commission established to administer the insurance laws of ~~this~~ *the* Commonwealth, *other than health insurance*

laws;

2. When used in Chapters 34, 35, 36, 42, 43, 56, and 58 of this title means the Health Insurance Commissioner; and

3. When used in any other chapter in this title, unless a contrary intent is specified or is implicit in the context, refers to both the head of the Bureau of Insurance and the Health Insurance Commissioner.

"Company" means any association, aggregate of individuals, business, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Domestic company" means a company incorporated or organized under the laws of this Commonwealth.

"Foreign company" means a company incorporated or organized under the laws of the United States, or of any state other than this Commonwealth.

"Health insurance commissioner" means the administrative or executive officer of the division or bureau of the Commission established to administer the health insurance laws of the Commonwealth.

"Health insurance laws of the Commonwealth" includes, without limitation, the provisions of Chapters 34 (§ 38.2-3400 et seq.), 35 (§ 38.2-3500 et seq.), 36 (§ 38.2-3600 et seq.), 42 (§ 38.2-3400 et seq.), 43 (§ 38.2-4300 et seq.), 56 (§ 38.2-5600 et seq.), and 58 (§ 38.2-5800 et seq.) of this title.

"Health services plan" means any arrangement for offering or administering health services or similar or related services by a corporation licensed under Chapter 42 (§ 38.2-4200 et seq.) of this title.

"Insurance" means the business of transferring risk by contract wherein a person, for a consideration, undertakes (i) to indemnify another person, (ii) to pay or provide a specified or ascertainable amount of money, or (iii) to provide a benefit or service upon the occurrence of a determinable risk contingency. Without limiting the foregoing, "insurance" shall include (i) each of the classifications of insurance set forth in Article 2 (§ 38.2-101 et seq.) of this chapter and (ii) the issuance of group and individual contracts, certificates, or evidences of coverage by any health services plan as provided for in Chapter 42 (§ 38.2-4200 et seq.) of this title, health maintenance organization as provided for in Chapter 43 (§ 38.2-4300 et seq.) of this title, legal services organization or legal services plan as provided for in Chapter 44 (§ 38.2-4400 et seq.) of this title, dental or optometric services plan as provided for in Chapter 45 (§ 38.2-4500 et seq.) of this title, and dental plan organization as provided for in Chapter 61 (§ 38.2-6100 et seq.) of this title. "Insurance" shall not include any activity involving an extended service contract that is subject to regulation pursuant to Chapter 34 (§ 59.1-435 et seq.) of Title 59.1 or a warranty made by a manufacturer, seller, lessor, or builder of a product or service.

"Insurance company" means any company engaged in the business of making contracts of insurance.

"Insurance transaction," "insurance business," and "business of insurance" include solicitation, negotiations preliminary to execution, execution of an insurance contract, and the transaction of matters subsequent to execution of the contract and arising out of it.

"Insurer" means an insurance company.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendment of 1965, as amended.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Rate" or "rates" means any rate of premium, policy fee, membership fee or any other charge made by an insurer for or in connection with a contract or policy of insurance. The terms "rate" or "rates" shall not include a membership fee paid to become a member of an organization or association, one of the benefits of which is the purchasing of insurance coverage.

"Rate service organization" means any organization or person, other than a joint underwriting association under § 38.2-1915 or any employee of an insurer including those insurers under common control or management, who assists insurers in ratemaking or filing by:

(a) Collecting, compiling, and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or

(c) Advising about rate questions, except as an attorney giving legal advice.

"State" means any commonwealth, state, territory, district or insular possession of the United States.

"Surplus to policyholders" means the excess of total admitted assets over the liabilities of an insurer, and shall be the sum of all capital and surplus accounts, including any voluntary reserves, minus any impairment of all capital and surplus accounts.

Without otherwise limiting the meaning of or defining the following terms, "insurance contracts" or "insurance policies" shall include contracts of fidelity, indemnity, guaranty and suretyship.

§38.2-200.1. Bureau of Insurance and Bureau of Health Insurance; Commissioner of Insurance and Health Insurance Commissioner.

A. The Bureau of Insurance shall exercise such of the powers and duties of the Commission

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pertaining to insurance, other than the health insurance laws of the Commonwealth, as are delegated to it pursuant to this title.

B. Pursuant to the provisions of § 12.1-16, the Commissioner of Insurance shall be the head of the Bureau of Insurance. With respect to the health insurance laws of the Commonwealth, the Health Insurance Commissioner shall discharge the powers and duties of office to:

1. Guard the solvency of health insurers;

2. Protect the interests of consumers;

3. Encourage fair treatment of health care providers;

4. Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

5. View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

C. The Bureau of Health Insurance shall exercise such of the powers and duties of the Commission pertaining to the health insurance laws of the Commonwealth as are delegated to it pursuant to § 12.1-16 and this title. The Health Insurance Commissioner's jurisdiction over enforcement of the health insurance laws of the Commonwealth shall be exercised independently from the Commissioner of Insurance.

D. Pursuant to the provisions of § 12.1-16, the Health Insurance Commissioner shall be the head of the Bureau of Health Insurance.

E. The Commissioner of Insurance and Health Insurance Commissioner shall each report directly to the Commission. The Commissioner of Insurance shall grant to the Health Insurance Commissioner reasonable access to appropriate expert staff within the Bureau of Insurance.

§ 38.2-229. Immunity from liability.

A. There shall be no liability on the part of and no cause of action against any person for furnishing in good faith to the Commission information relating to the investigation of any insurance or reinsurance transaction when such information is furnished under the requirements of law or at the request or direction of the Commission.

B. There shall be no liability on the part of and no cause of action against the Commission, the Commissioner of Insurance, *the Commissioner of Health Insurance,* or any of the Commission's employees or agents, acting in good faith, for investigating any insurance or reinsurance transaction or for the dissemination of any official report related to an official investigation of any insurance or reinsurance transaction.

§ 38.2-305. Contents of policies.

A. Each insurance policy or contract shall specify:

1. The names of the parties to the contract;

2. The subject of the insurance;

3. The risks insured against;

4. The time the insurance takes effect and, except in the case of group insurance, title insurance, and insurance written under perpetual policies, the period during which the insurance is to continue;

5. A statement of the premium, except in the case of group insurance and title insurance; and

6. The conditions pertaining to the insurance.

B. Each new or renewal insurance policy, contract, certificate or evidence of coverage issued to a policyholder, covered person or enrollee shall be accompanied by a notice stating substantially:

"IMPORTANT INFORMATION REGARDING YOUR INSURANCE"

"In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number —*[*Insert the appropriate address and telephone number, toll free number if available, for the company's home or regional office].

Health maintenance organizations shall add the following: We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance, *or Bureau of Health Insurance if the policy is written under the health insurance laws of the Commonwealth,* at: —*[*Insert the appropriate address, toll free phone number, and phone number for out-of-state calls for the Bureau of Insurance *or Bureau of Health Insurance, as applicable*].

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance *or Bureau of Health Insurance,* have your policy number available."

C. In any life insurance or annuity contract containing a beneficiary designation in which the designated beneficiary is the spouse of the policy owner, the following notice shall be included with the

policy when issued, either attached to or incorporated into the front or first page of such contract:

"BENEFICIARY DESIGNATION MAY NOT APPLY IN THE EVENT OF ANNULMENT OR DIVORCE"

"Under Virginia law (Virginia Code § 20-111.1), a revocable beneficiary designation in a policy owned by one spouse that names the other spouse as beneficiary becomes void upon the entry of a decree of annulment or divorce, and the death benefit prevented from passing to a former spouse will be paid as if the former spouse had predeceased the decedent. In the event of annulment or divorce proceedings, and if it is the intent of the parties that the beneficiary designation of the former spouse is to continue, you are advised to make certain that one of the following courses of action is taken prior to the entry of a decree of annulment or divorce: (i) change the beneficiary designation to make it irrevocable; (ii) change the ownership of the policy or contract; (iii) execute a separate written agreement stating the intention of both parties that the beneficiary designation is to remain in effect beyond the date of entry of the decree of annulment or divorce; or (iv) make certain that the decree of annulment or divorce contains a provision stating that the beneficiary designation is not to be revoked pursuant to § 20-111.1."

D. If, under the contract, the exact amount of premiums is determinable only at the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid shall be furnished to any policy-examining bureau having jurisdiction or to the insured upon request.

E. This section shall not apply to surety insurance contracts.

§ 38.2-400. Expense of administration of insurance laws borne by licensees; minimum contribution.

A. The expense of maintaining the Bureau of ~~the Commission responsible for administering the insurance laws of this Commonwealth~~ *Insurance and the Bureau of Health Insurance*, including a reasonable margin in the nature of a reserve fund, shall be assessed annually by the Commission against all companies and surplus lines brokers subject to this title except premium finance companies and providers of continuing care registered pursuant to Chapter 49 (§ 38.2-4900 et seq.) of this title. The assessment shall be in proportion to the direct gross premium income on business done in this Commonwealth. The assessment shall not exceed one-tenth of one percent of the direct gross premium income and shall be levied pursuant to § 38.2-403. For any year a company is subject to an assessment, the assessment shall not be less than $300.

B. All fees assessed under any provision of this title and paid into the state treasury shall be deposited to a special fund designated "Bureau of Insurance Special Fund - State Corporation Commission," ~~and out~~ *without regard to whether the entity subject to such assessment is supervised by the Bureau of Insurance or the Bureau of Health Insurance. Out* of such special fund and the unexpended balance thereof shall be appropriated the sums necessary for the regulation, supervision and examination of all entities subject to regulation under this title. Any references in the Code of Virginia to funds being paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance shall hereinafter mean the "Bureau of Insurance Special Fund - State Corporation Commission."

§ 54.1-2909. Further reporting requirements; civil penalty; disciplinary action.

A. The following matters shall be reported within 30 days of their occurrence to the Board:

1. Any disciplinary action taken against a person licensed under this chapter in another state or in a federal health institution or voluntary surrender of a license in another state while under investigation;

2. Any malpractice judgment against a person licensed under this chapter;

3. Any settlement of a malpractice claim against a person licensed under this chapter; and

4. Any evidence that indicates a reasonable probability that a person licensed under this chapter is or may be professionally incompetent; has engaged in intentional or negligent conduct that causes or it likely to cause injury to a patient or patients; has engaged in unprofessional conduct; or may be mentally or physically unable to engage safely in the practice of his profession.

The reporting requirements set forth in this section shall be met if these matters are reported to the National Practitioner Data Bank under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq., and notice that such a report has been submitted is provided to the Board.

B. The following persons and entities are subject to the reporting requirements set forth in this section:

1. Any person licensed under this chapter who is the subject of a disciplinary action, settlement, judgment or evidence for which reporting is required pursuant to this section;

2. Any other person licensed under this chapter, except as provided in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;

3. The presidents of all professional societies in the Commonwealth, and their component societies whose members are regulated by the Board, except as provided for in the protocol agreement entered

into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;

4. All health care institutions licensed by the Commonwealth;

5. The malpractice insurance carrier of any person who is the subject of a judgment or settlement; and

6. Any health maintenance organization licensed by the Commonwealth.

C. No person or entity shall be obligated to report any matter to the Board if the person or entity has actual notice that the matter has already been reported to the Board.

D. Any report required by this section shall be in writing directed to the Board, shall give the name and address of the person who is the subject of the report and shall describe the circumstances surrounding the facts required to be reported. Under no circumstances shall compliance with this section be construed to waive or limit the privilege provided in § 8.01-581.17.

E. Any person making a report required by this section, providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability or criminal prosecution resulting therefrom unless such person acted in bad faith or with malicious intent.

F. The clerk of any circuit court or any district court in the Commonwealth shall report to the Board the conviction of any person known by such clerk to be licensed under this chapter of any (i) misdemeanor involving a controlled substance, marijuana or substance abuse or involving an act of moral turpitude or (ii) felony.

G. Any person who fails to make a report to the Board as required by this section shall be subject to a civil penalty not to exceed $5,000. The Director shall report the assessment of such civil penalty to the Commissioner of the Department of Health or the Commissioner of *Health* Insurance at the State Corporation Commission. Any person assessed a civil penalty pursuant to this section shall not receive a license, registration or certification or renewal of such unless such penalty has been paid.

H. Disciplinary action against any person licensed, registered or certified under this chapter shall be based upon the underlying conduct of the person and not upon the report of a settlement or judgment submitted under this section.