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HOUSE BILL NO. 1005

House Amendments in [ ] — January 24, 2014

A BILL to amend and reenact §§ 38.2-3407.12, 38.2-3407.16, 38.2-3407.18, 38.2-3414, 38.2-3414.1, 38.2-3417, 38.2-3418.9, 38.2-3418.10, 38.2-3418.13 through 38.2-3418.16, 38.2-3430.6, 38.2-3438, 38.2-3541, 38.2-4217, 38.2-4306, 38.2-4310, and 38.2-4319 of the Code of Virginia and to repeal §§ 38.2-3416 and 38.2-3541.1 of the Code of Virginia, relating to health benefit plans; individual and group coverage.

Patron Prior to Engrossment—Delegate Byron

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3407.12, 38.2-3407.16, 38.2-3407.18, 38.2-3414, 38.2-3414.1, 38.2-3417, 38.2-3418.9, 38.2-3418.10, 38.2-3418.13 through 38.2-3418.16, 38.2-3430.6, 38.2-3438, 38.2-3541, 38.2-4217, 38.2-4306, 38.2-4310, and 38.2-4319 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3407.12. Patient optional point-of-service benefit.

A. As used in this section:

"Affiliate" shall have the meaning set forth in § 38.2-1322.

"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;

2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services plans which are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;

3. Any health maintenance organization licensed under this title which provides or arranges for the provision of one or more health care plans which are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;

4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans which are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and

5. Any other person licensed under this title which provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels which are subject to regulation as the business of insurance under this title.

"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service which is not paid by the carrier and for which the enrollee is responsible.

"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the enrollee to the provider towards the allowable charge as a condition of the receipt of specific health care items and services.

"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the enrollee as a condition to or consequence of the receipt of covered items or services.

"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.

"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.

"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.

"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover

all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; or (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded.

"Group specific administrative cost" means the direct administrative cost incurred by a carrier related to the offer of the point-of-service benefit to a particular group contract holder.

"Health care plan" shall have the meaning set forth in § 38.2-4300.

"Person" means any individual, corporation, trust, association, partnership, limited liability company, organization or other entity.

"Point-of-service benefit" means a health maintenance organization's delivery system or covered benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with the health maintenance organization, which permit an enrollee (and eligible dependents) to receive covered items and services outside of the provider panel, including optometrists and clinical psychologists, of the health maintenance organization under the terms and conditions of the group contract holder's group health benefit plan with the health maintenance organization or with another carrier arranged by or under contract with the health maintenance organization and which otherwise complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee (and eligible dependents) to receive the full range of covered items and services outside of a provider panel, including optometrists and clinical psychologists, and which are otherwise in compliance with applicable law and this section shall constitute a point-of-service benefit.

"Preferred provider organization plan" means a health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209.

"Provider" means any physician, hospital or other person, including optometrists and clinical psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health care items or services.

"Provider panel" means the participating providers or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health maintenance organization or other carrier.

B. To the maximum extent permitted by applicable law, every health care plan offered or proposed to be offered in ~~this~~ *the large group market in the* Commonwealth by a health maintenance organization licensed under this title to a group contract holder shall provide or include, or the health maintenance organization shall arrange for or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered in conjunction with the health maintenance organization's health care plan as an additional benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every health maintenance organization shall, at no additional cost to the group contract holder, make available or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance acceptable to the Commission which accurately and completely explains to the group contract holder and prospective enrollee the point-of-service benefit and permits each enrollee to make his or her election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the carrier in any reasonable manner.

C. To the extent permitted under applicable law, a health maintenance organization providing or arranging, or contracting with another carrier to provide, the point-of-service benefit under this section and a carrier providing the point-of-service benefit required under this section under arrangement or contract with a health maintenance organization:

1. May not impose, or permit to be imposed, a minimum enrollee participation level on the point-of-service benefit alone;

2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or

38.2-4221 for items or services provided under the point-of-service benefit required under this section solely on the basis of the license or certification of the provider to provide such items or services if the carrier otherwise covers the items or services provided and the provision of the items or services is within the provider's lawful scope of practice or authority; and

3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group prior to any enrollee electing to accept or reject the point-of-service benefit.

D. The premium imposed by a carrier with respect to enrollees who select the point-of-service benefit may be different from that imposed by the health maintenance organization with respect to enrollees who do not select the point-of-service benefit. Unless a group contract holder determines otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of any premium over the amount of the premium applicable to an enrollee who selects the coverage offered by the health maintenance organization without the point-of-service benefit and for any identifiable group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization; provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) thirty percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service

benefit any condition or penalty designed to discourage the enrollee's selection or use of the point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

H. Except as expressly otherwise permitted in this section or as otherwise required under applicable law, the scope of the health care items and services which are covered under the point-of-service benefit required under this section shall at least include the same health care items and services which would be covered if provided under the health maintenance organization's health care plan, including without limitation any items or services covered under a rider or endorsement to the applicable health care plan. Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing materials utilized with respect to such group health benefit plans that the scope of the benefits provided under the point-of-service option are at least as great as those provided through the HMO's health care plan for that group. Filings of point-of-service benefits submitted to the Commission shall be accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the point-of-service benefits includes at a minimum the same health care items and services as are provided under the HMO's group health care plan for that group.

I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the health maintenance organization's group health benefit plan which does not contain the point-of-service benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is offered in a manner which separates or otherwise differentiates it from the group health benefit plan which does not contain the point-of-service benefit.

J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit under this section with respect to any group health benefit plan offered to a group contract holder if the health maintenance organization determines in good faith that the group contract holder will be concurrently offering another group health benefit plan or a self-insured or self-funded health benefit plan which allows the enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization's panel.

K. This section shall apply only to group health benefit plans issued in the Commonwealth in the commercial *large* group market by carriers regulated by this title and shall not apply to (i) health care plans, contracts or policies issued in the individual *or small group* market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; [~~or~~] (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded [*; or (v) a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the federal Patient Protection and Affordable Care Act (P.L. 111-148)*] .

L. ~~This section shall apply to group health benefit plans issued or renewed by carriers in this Commonwealth on or after July 1, 1998.~~

~~M.~~ Nothing in this section shall operate to limit any rights or obligations arising under § 38.2-3407, 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312, or 38.2-4312.1.

~~N.~~ *M.* If any provision of this section or its application to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity shall not affect the other provisions or any other application of this section which shall be given effect without the invalid provision or application, and for this purpose the provisions of this section are declared severable.

§ 38.2-3407.16. Requirements for obstetrical care.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health

maintenance organization providing a health care plan for health care services, whose policies, contracts, or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts or plans, include coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical illness generally.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made, on and after the effective date of this section. The provisions of this section shall not apply to short-term travel, accident only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3407.18. Requirements for orally administered cancer chemotherapy drugs.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts, or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts, or plans, include coverage for cancer chemotherapy drugs administered orally and intravenously or by injection shall provide that the criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made, on and after the effective date of this section. The provisions of this section shall not apply to short-term travel, accident only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

C. This section shall apply to health coverage offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, local officers, teachers and retirees pursuant to § 2.2-1204. In administering such coverage, the criteria for establishing the level of copayments or coinsurance for orally administered cancer treatment drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

§ 38.2-3414. Optional coverage for obstetrical services.

A. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue group hospital, group medical or group major medical subscription contracts shall provide coverage for obstetrical services as an option available to the group policyholder or the contract holder in the case of benefits based upon treatment as an inpatient in a general hospital. The reimbursement for obstetrical services by a physician shall be based on the charges for the services determined according to the same formula by which the charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

B. This section shall not apply to short-term travel, accident only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3414.1. Obstetrical benefits; coverage for postpartum services.

A. Each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care services that provides benefits for obstetrical services shall provide coverage for postpartum services as provided in this section.

B. Such coverage shall include benefits for inpatient care and a home visit or visits which 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.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 1996, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

D. This section shall not apply to short-term travel, accident only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3417. Deductibles and coinsurance options required.

A. An insurer issuing accident and sickness insurance or a corporation issuing subscription contracts on an expense incurred basis shall make available in offering such coverage or contract to the potential insured or contract holder one or more of the following options under which the individual insured or group certificate holder pays for:

1. The first $100 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period;

2. Twenty percent of the first $1,000 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period;

3. The first $100 and 20 percent of the next $1,000 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period; or

4. Any other option containing a greater deductible, coinsurance, or cost-sharing provision. However, the option shall not be inconsistent with standards established with respect to deductibles, coinsurance, or cost-sharing pursuant to § 38.2-3519.

B. As used in this section, "make available" means that the insurer or corporation shall disseminate information concerning the option or options and make a policy or contract containing the option or options available to potential insureds or contract holders at the same time and in the same manner as the insurer or corporation disseminates information concerning other policies or contracts and coverage options and makes other policies or contracts and coverage options available.

C. This section shall not apply to short-term travel, accident only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

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

§ 38.2-3418.9. Minimum hospital stay for hysterectomy.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care shall provide coverage for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy as provided in this section.

B. Such coverage shall include benefits for a minimum stay in the hospital of not less than ~~twenty-three~~ *23* hours for a laparoscopy-assisted vaginal hysterectomy and ~~forty-eight~~ *48* hours for a vaginal hysterectomy. Nothing in this subsection shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 1999, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

D. This section shall not apply to short-term travel, accident-only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3418.10. Coverage for diabetes.

A. Each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care services shall provide coverage for diabetes as provided in this section.

B. Such coverage shall include benefits for equipment, supplies and in-person 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 health care professional legally authorized to prescribe such items under law. As used herein, the terms "equipment" and "supplies" shall not be considered durable medical equipment.

C. To qualify for coverage under this section, diabetes in-person outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional. A

managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of this title, may require such health care professional to be a member of the plan's provider network; provided that such network includes sufficient health care professionals who are qualified by specific education, experience, and credentials to provide the covered benefits described in this section.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, nor shall any insurer, corporation or health maintenance organization impose any policy-year or calendar-year dollar or durational benefit limitations or maximums for benefits or services provided under this section.

E. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 2000, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

F. This section shall not apply to short-term travel, accident only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3418.13. Coverage for the treatment of morbid obesity.

A. Notwithstanding the provisions of § 38.2-3419, *in the large group market,* each insurer proposing to issue [~~individual or group~~] accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing ~~individual or~~ [~~group~~] accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall offer and make available coverage under any such policy, contract or plan 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. ~~The provisions of this section shall apply to any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 2000.~~

B. The reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed 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. Standards and criteria, including those related to diet, used by insurers to approve or restrict access to surgery for morbid obesity shall be based upon current clinical guidelines recognized by the National Institutes of Health.

C. For purposes of this section, "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.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration [*; health care plans, contracts, or policies issued in the individual or small group market; or a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the federal Patient Protection and Affordable Care Act (P.L. 111-148)*] .

§ 38.2-3418.14. Coverage for lymphedema.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical, coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for lymphedema as provided in this section.

B. Coverage under this section shall include benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

C. A managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of this title, may require such health care professional to be a member of the plan's provider network, provided that such network includes sufficient health care professionals who are qualified by specific education, experience, and credentials to provide the covered benefits described in this section.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee, policy year or calendar year, or durational

benefit limitation or maximum for benefits or services that is not equally imposed upon all individuals in the same benefit category.

E. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended in this Commonwealth on and after January 1, 2004, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

F. This section shall not apply to short-term travel, accident only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3418.15. Coverage for prosthetic devices and components.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall offer and make available coverage for medically necessary prosthetic devices, their repair, fitting, replacement, and components, as follows:

1. As used in this section:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

2. Prosthetic device coverage does not include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not include prosthetic devices designed primarily for an athletic purpose.

3. An insurer shall not impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. The coverage may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

4. An insurer shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

5. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any coinsurance in excess of 30 percent of the carrier's allowable charge for such prosthetic device or services when such device or service is provided by an in-network provider.

6. An insurer, corporation, or health maintenance organization may require preauthorization to determine medical necessity and the eligibility of benefits for prosthetic devices and components, in the same manner that prior authorization is required for any other covered benefit.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2010, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

C. This section shall not apply to short-term travel, accident-only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3418.16. Coverage for telemedicine services.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section, "telemedicine services," as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. "Telemedicine services" do not include an audio-only telephone, electronic mail message, or facsimile transmission.

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services

appropriately provided through telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, *or* limited or specified disease~~, or individual conversion~~ policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3430.6. Market requirements.

~~A.~~ The provisions of § 38.2-3430.3 shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

~~B. A health insurance issuer offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.~~

§ 38.2-3438. Definitions.

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

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child or any other child eligible for coverage under the health benefit plan.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition: (i) a medical screening examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities

available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd(e)(3)) to stabilize the patient.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"Essential health benefits" include the following general categories and the items and services covered within the categories in accordance with regulations issued pursuant to the PPACA: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices.

"Facility" means an institution providing health care related services or a health care setting, including but not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Genetic information" means, with respect to an individual, information about: (i) the individual's genetic tests; (ii) the genetic tests of the individual's family members; (iii) the manifestation of a disease or disorder in family members of the individual; or (iv) any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. "Genetic information" does not include information about the sex or age of any individual. As used in this definition, "family member" includes a first-degree, second-degree, third-degree, or fourth-degree relative of a covered person.

"Genetic services" means (i) a genetic test; (ii) genetic counseling, including obtaining, interpreting, or assessing genetic information; or (iii) genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

"Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on March 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of coverage to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long as such plan maintains that status in accordance with federal law.

"Group health insurance coverage" means health insurance coverage offered in connection with a group health benefit plan.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.).

"Health status-related factor" means any of the following factors: health status; medical condition, including physical and mental illnesses; claims experience; receipt of health care services; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; disability; or any other health status-related factor as determined by federal regulation.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include coverage defined as "excepted benefits" in § 38.2-3431 or short-term limited duration insurance. Student

health insurance coverage shall be considered a type of individual health insurance coverage. ~~A health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.~~

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Network" means the group of participating providers providing services to a managed care plan.

"Open enrollment" means, with respect to individual health insurance coverage, the period of time during which any individual has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and must be accepted for coverage under the plan without regard to a preexisting condition exclusion.

"Participating health care professional" means a health care professional who, under contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

"Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. "Preexisting condition exclusion" also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination given to an individual, or review of medical records relating to the pre-enrollment period.

"Premium" means all moneys paid by an employer, eligible employee, or covered person as a condition of coverage from a health carrier, including fees and other contributions associated with the health benefit plan.

"Primary care health care professional" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

2. A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

"Stabilize" means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

"Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965, and a health carrier and provided to students enrolled in that institution of higher education and their dependents, and that does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education, and does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

"Wellness program" means a program offered by an employer that is designed to promote health or prevent disease.

§ 38.2-3541. Continuation on termination of eligibility.

A. Each group hospital policy, group medical and surgical policy, or group major medical policy delivered or issued for delivery in ~~this~~ *the* Commonwealth or renewed, reissued, or extended if already

issued~~,~~ shall contain~~, subject to the policyholder's selection, one of the options set forth in this section. Option 1 shall apply~~ *a provision for continuation of coverage under the group policy* if the insurance on a person covered under such a policy ceases because of the termination of the person's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits ~~unless such termination is due to termination of the group policy under circumstances in which the insured person is insurable under other replacement group coverage or health care plan without waiting periods or preexisting conditions under the replacement coverage or plan. Option 2 shall apply if the insurance on a person covered under such a policy that remains in force ceases because of the termination of the person's eligibility for coverage prior to that person becoming eligible for Medicare or Medicaid benefits. Option 2~~. *This provision* shall not be applicable if the group policyholder is required by federal law to provide for continuation of coverage under its group health plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

~~1. Option 1: To have the insurer issue him, without evidence of insurability, an individual accident and sickness insurance policy in the event that the insurer is not exempt under § 38.2-3416 and offers such policy, subject to the following requirements:~~

~~a. The application for the policy shall be made, and the first premium paid to the insurer within thirty-one days after issuance of the written notice required in subdivision 3, but in no event beyond the 60 day period following the date of the termination of the person's eligibility;~~

~~b. The premium on the policy shall be at the insurer's then customary rate applicable: (i) to such policies, (ii) to the class of risk to which the person then belongs, and (iii) to his or her age on the effective date of the policy;~~

~~c. The policy will not result in over-insurance on the basis of the insurer's underwriting standards at the time of issue;~~

~~d. The benefits under the policy shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;~~

~~e. The policy shall extend coverage to the same family members that were insured under the group policy; and~~

~~f. Coverage under this option shall be effected in such a way as to result in continuous coverage from the date of the insured's termination of eligibility for such insured if requested and paid for by the insured.~~

~~2. Option 2: To have his~~ *B. The insured's* present coverage *shall continue* under the policy ~~continued~~ for a period of 12 months immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

~~a.~~ *1.* The application and payment for the extended coverage is made to the group policyholder within 31 days after issuance of the written notice required in ~~subdivision 3~~ *subsection C*, but in no event beyond the ~~60 day~~ *60-day* period following the date of the termination of the person's eligibility;

~~b.~~ *2.* Each premium for such extended coverage is timely paid to the group policyholder on a monthly basis during the ~~twelve-month~~ *12-month* period;

~~c.~~ *3.* The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative fee not to exceed two percent of the current rate; and

~~d.~~ *4.* Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire ~~three months'~~ *three-month* period immediately preceding termination of eligibility.

~~3.~~ *C.* The group policyholder shall provide each employee or other person covered under such a policy written notice of the availability of ~~the option chosen~~ *continuation of coverage* and the procedures and timeframes for obtaining continuation ~~or conversion~~ of the group policy. Such notice shall be provided within 14 days of the policyholder's knowledge of the employee's or other covered person's loss of eligibility under the policy.

§ 38.2-4217. Reports.

A. In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file on a quarterly basis any additional reports, exhibits or statements the Commission considers necessary to furnish full information concerning the condition, solvency, experience, transactions or affairs of the nonstock corporation. The Commission shall establish deadlines for submitting any additional reports, exhibits or statements. The Commission may require verification by any officers of the nonstock corporation the Commission designates.

B. In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file annually, on or before June 1, an annual statement, signed by two of its principal officers subject to § 38.2-1304, showing:

1. The number of Virginia subscribers by the following type of contract or its equivalent:

a. Individual, open enrollment; *and*

b. Medicare, extended, under 65 disabled; ~~and~~

~~c. Individual conversion subscribers.~~

2. The subscriber income and benefit payments in the aggregate for the types of contracts listed above subject to specific breakdown by type of contract as requested by the Commission; and

3. Expenditures for providing public services, in addition to open enrollment, to the community.

§ 38.2-4306. Evidence of coverage and charges for health care services.

A. 1. Each subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the Commission, subject to the provisions of subsection C of this section. Any evidence of coverage for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, is excluded from the provisions of this section.

3. No evidence of coverage shall contain provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.

4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

a. The health care services and any insurance or other benefits to which the enrollee is entitled under the health care plan;

b. Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature, or both;

c. Where and in what manner information is available as to how services may be obtained;

d. The total amount of payment for health care services and any indemnity or service benefits that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory for group certificates;

e. A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee; *and*

f. A list of providers and a description of the service area which shall be provided with the evidence of coverage, if such information is not given to the subscriber at the time of enrollment~~; and~~

~~g. Any right of subscribers covered under a group contract to convert their coverages to an individual contract issued by the health maintenance organization.~~

B. Pursuant to this subsection:

1. No schedule of charges or amendment to the schedule of charges for enrollee coverage for health care services may be used in conjunction with any health care plan until a copy of the schedule, or its amendment, has been filed with the Commission. Any schedule of charges or amendment to the schedule of charges for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, is excluded from the provisions of this subsection.

2. The charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applying to an enrollee in a group health plan shall not be individually determined based on the status of his health. A certification on the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information. This certification shall be prepared by a qualified actuary or other qualified professional approved by the Commission.

C. The Commission shall, within a reasonable period, approve any form if the requirements of subsection A of this section are met. It shall be unlawful to issue a form until approved. If the Commission disapproves a filing, it shall notify the filer. The Commission shall specify the reasons for its disapproval in the notice. A written request for a hearing on the disapproval may be made to the Commission within 30 days after notice of the disapproval. If the Commission does not disapprove any form within 30 days of the filing of such form, it shall be deemed approved unless the filer is notified in writing that the waiting period is extended by the Commission for an additional 30 days. Filing of the form means actual receipt by the Commission.

D. The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing made under this section.

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

§ 38.2-4310. Protection against insolvency.

A. Each health maintenance organization shall deposit and maintain acceptable securities with the State Treasurer in amounts prescribed by § 38.2-4310.1. The deposit shall be held as a special fund in trust, as a guarantee that the obligations to the enrollees who are residents of this Commonwealth will be performed. The securities shall be deposited pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership interests effected on the records of a depository

and its participants pursuant to rules and procedures established by the depository. Upon a determination of insolvency or action by the Commission pursuant to § 38.2-4317, the deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of covered services to enrollees. If a health maintenance organization is placed in receivership, the deposit shall be an asset subject to the provisions of Chapter 15 (§ 38.2-1500 et seq.) of this title.

B. The Commission may require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Commission may require:

1. Insurance satisfactory in form and content to the Commission to cover the expenses to be paid for continued benefits after an insolvency;

2. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

3. Acceptable letters of credit; or

4. Any other arrangements to assure that benefits are continued as specified above.

C. 1. In the event of an insolvency of a health maintenance organization, all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon a date to be prescribed by the Commission. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates then in effect for its enrollees in such group.

2. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the Commission determines that the other health benefit plan lacks sufficient health care delivery resources to assure that health care services shall be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the Commission may allocate equitably the insolvent health maintenance organization's group contracts for such groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer such group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

3. The Commission may also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer such nongroup enrollees the health maintenance organization's existing coverage for individual ~~or conversion~~ coverage as determined by his type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

D. 1. Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

2. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those employees and dependents validly covered under the prior carrier's contract or policy on the date of discontinuance.

~~E. [Repealed.]~~

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

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this

chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.18, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, ~~38.2-3541.1,~~ 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

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

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

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

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

2. That §§ 38.2-3416 and 38.2-3541.1 of the Code of Virginia are repealed.