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HOUSE BILL NO. 1747

Offered January 14, 2015

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A BILL to amend and reenact §§ 38.2-3412.1, 38.2-3418.17, 38.2-4300, 38.2-4319, and 38.2-5800 of the Code of Virginia and to repeal § 38.2-3412.1:01 of the Code of Virginia, relating to health insurance; mental health parity; transparency of claims denial information.

Patron—O'Bannon

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3412.1, 38.2-3418.17, 38.2-4300, 38.2-4319, and 38.2-5800 of the Code of Virginia are amended and reenacted as follows:

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

A. As used in this section:

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

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

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

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

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

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

"Mental health services" or "mental health benefits" means ~~treatment for mental, emotional or nervous disorders~~ *benefits with respect to items or services for mental health conditions as defined under the terms of the health benefit plan. Any condition defined by the health benefit plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice.*

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

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

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

"Substance abuse services" or "substance use disorder benefits" means ~~treatment for alcohol or other drug dependence~~ *benefits with respect to items or services for substance use disorders as defined under the terms of the health benefit plan. Any disorder defined by the health benefit plan as being or as not*

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59 *being a substance use disorder shall be defined to be consistent with generally recognized independent*
60 *standards of current medical practice.*

61 "Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological
62 care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence
63 rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health
64 treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed
65 professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family
66 therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or
67 psychological dependence on alcohol or other drugs shall also include the services of counseling and
68 rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse
69 counselor or substance abuse counseling assistant, limited to the scope of practice set forth in
70 § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed to provide such
71 treatment.

72 B. Except for group health insurance coverage issued to a large employer as defined in § 38.2-3431,
73 each individual and group accident and sickness insurance policy or individual and group subscription
74 contract providing coverage on an expense-incurred basis for a family member of the insured or the
75 subscriber as provided in subsections C and D, group and individual health insurance coverage, as
76 defined in § 38.2-3431, shall provide mental health and substance use disorder benefits. Such benefits
77 shall be in parity with the medical and surgical benefits contained in the coverage in accordance with
78 the Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, even where those
79 requirements would not otherwise apply directly.

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

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

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

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

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

99 5. This subsection shall not apply to short-term travel, accident only, limited or specified disease
100 policies or contracts any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts
101 designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act,
102 known as Medicare, or any other similar coverage under state or federal governmental plans.

103 C. Except for group health insurance coverage issued to a large employer as defined in § 38.2-3431,
104 each individual and group accident and sickness insurance policy or individual and group subscription
105 contract providing coverage on an expense-incurred basis for a family member of the insured or the
106 subscriber D. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall also
107 either continue to provide benefits in accordance with subsection B or continue to provide coverage for
108 outpatient mental health and substance abuse services as follows:

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

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

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

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

120 5. This subsection shall not apply to short-term travel, accident only, or limited or specified disease

121 policies or contracts any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts
 122 designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act,
 123 known as Medicare, or any other similar coverage under state or federal governmental plans.

124 D. The provisions of this section shall not be applicable to "biologically based mental illnesses," as
 125 defined in § 38.2-3412.1-01, unless coverage for any such mental illness is not otherwise available
 126 pursuant to the provisions § 38.2-3412.1-01.

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

130 F. Group health insurance coverage issued to a large employer as defined in § 38.2-3431 shall
 131 provide mental health and substance use disorder benefits in parity with the medical and surgical
 132 benefits contained in the coverage in accordance with the Mental Health Parity and Addiction Equity
 133 Act of 2008 (P.L. 110-343).

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

136 **§ 38.2-3418.17. Coverage for autism spectrum disorder.**

137 A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue group accident and
 138 sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an
 139 expense-incurred basis; each corporation providing group accident and sickness subscription contracts;
 140 and each health maintenance organization providing a health care plan for health care services shall, as
 141 provided in this section, provide coverage for the diagnosis of autism spectrum disorder and the
 142 treatment of autism spectrum disorder in individuals from age two through age six, subject to the annual
 143 maximum benefit limitation set forth in subsection K. If an individual who is being treated for autism
 144 spectrum disorder becomes seven years of age or older and continues to need treatment, this section
 145 does not preclude coverage of treatment and services. In addition to the requirements imposed on health
 146 insurance issuers by § 38.2-3436, an insurer shall not terminate coverage or refuse to deliver, issue,
 147 amend, adjust, or renew coverage of an individual solely because the individual is diagnosed with
 148 autism spectrum disorder or has received treatment for autism spectrum disorder.

149 B. For purposes of this section:

150 "Applied behavior analysis" means the design, implementation, and evaluation of environmental
 151 modifications, using behavioral stimuli and consequences, to produce socially significant improvement in
 152 human behavior, including the use of direct observation, measurement, and functional analysis of the
 153 relationship between environment and behavior.

154 "Autism spectrum disorder" means any pervasive developmental disorder, including (i) autistic
 155 disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v)
 156 Pervasive Developmental Disorder - Not Otherwise Specified, as defined in the most recent edition of
 157 the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

158 "Behavioral health treatment" means professional, counseling, and guidance services and treatment
 159 programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the
 160 functioning of an individual.

161 "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests
 162 to diagnose whether an individual has an autism spectrum disorder.

163 "Medically necessary" means based upon evidence and reasonably expected to do any of the
 164 following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the
 165 physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to
 166 achieve or maintain maximum functional capacity in performing daily activities, taking into account both
 167 the functional capacity of the individual and the functional capacities that are appropriate for individuals
 168 of the same age.

169 "Pharmacy care" means medications prescribed by a licensed physician and any health-related
 170 services deemed medically necessary to determine the need or effectiveness of the medications.

171 "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the
 172 state in which the psychiatrist practices.

173 "Psychological care" means direct or consultative services provided by a psychologist licensed in the
 174 state in which the psychologist practices.

175 "Therapeutic care" means services provided by licensed or certified speech therapists, occupational
 176 therapists, physical therapists, or clinical social workers.

177 "Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the
 178 following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a
 179 licensed physician or a licensed psychologist who determines the care to be medically necessary: (i)
 180 behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v)
 181 therapeutic care, and (vi) applied behavior analysis when provided or supervised by a board certified

182 behavior analyst who shall be licensed by the Board of Medicine. The prescribing practitioner shall be
183 independent of the provider of applied behavior analysis.

184 "Treatment plan" means a plan for the treatment of autism spectrum disorder developed by a licensed
185 physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed
186 in a manner consistent with the most recent clinical report or recommendation of the American
187 Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

188 C. Except for inpatient services, if an individual is receiving treatment for an autism spectrum
189 disorder, an insurer, corporation, or health maintenance organization shall have the right to request a
190 review of that treatment, including an independent review, not more than once every 12 months unless
191 the insurer, corporation, or health maintenance organization and the individual's licensed physician or
192 licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review,
193 including an independent review, shall be covered under the policy, contract, or plan.

194 D. Coverage under this section will not be subject to any visit limits, and shall be neither different
195 nor separate from coverage for any other illness, condition, or disorder for purposes of determining
196 deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for
197 deductibles and copayment and coinsurance factors.

198 E. Nothing shall preclude the undertaking of usual and customary procedures, including prior
199 authorization, to determine the appropriateness of, and medical necessity for, treatment of autism
200 spectrum disorder under this section, provided that all such appropriateness and medical necessity
201 determinations are made in the same manner as those determinations are made for the treatment of any
202 other illness, condition, or disorder covered by such policy, contract, or plan.

203 F. The provisions of this section shall not apply to (i) short-term travel, accident only, limited, or
204 specified disease policies; (ii) short-term nonrenewable policies of not more than six months' duration;
205 (iii) policies, contracts, or plans issued in the individual market or small group markets to employers
206 with 50 or fewer employees; or (iv) policies or contracts designed for issuance to persons eligible for
207 coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar
208 coverage under state or federal governmental plans.

209 G. The requirements of this section shall apply to all insurance policies, subscription contracts, and
210 health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2012, and to
211 all such policies, contracts, or plans to which a term is changed or any premium adjustment is made on
212 or after such date.

213 H. Any coverage required pursuant to this section shall be in addition to the coverage required by
214 § 38.2-3418.5 and other provisions of law. This section shall not be construed as diminishing any
215 coverage required by ~~§ 38.2-3412.1-04~~ 38.2-3412.1. This section shall not be construed as affecting any
216 obligation to provide services to an individual under an individualized family service plan, an
217 individualized education program, or an individualized service plan.

218 I. Pursuant to the provisions of § 2.2-2818.2, this section shall apply to health coverage offered to
219 state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local
220 governments, local officers, teachers, and retirees, and the dependents of such employees, teachers, and
221 retirees pursuant to § 2.2-1204.

222 J. Notwithstanding any provision of this section to the contrary:

223 1. An insurer, corporation, or health maintenance organization, or a governmental entity providing
224 coverage for such treatment pursuant to subsection I, is exempt from providing coverage for behavioral
225 health treatment required under this section and not covered by the insurer, corporation, health
226 maintenance organization, or governmental entity providing coverage for such treatment pursuant to
227 subsection I as of December 31, 2011, if:

228 a. An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a
229 member of the American Academy of Actuaries and meets the American Academy of Actuaries'
230 professional qualification standards for rendering an actuarial opinion related to health insurance rate
231 making, certifies in writing to the Commissioner of Insurance that:

232 (1) Based on an analysis to be completed no more frequently than one time per year by each insurer,
233 corporation, or health maintenance organization, or such governmental entity, for the most recent
234 experience period of at least one year's duration, the costs associated with coverage of behavioral health
235 treatment required under this section, and not covered as of December 31, 2011, exceeded one percent
236 of the premiums charged over the experience period by the insurer, corporation, or health maintenance
237 organization; and

238 (2) Those costs solely would lead to an increase in average premiums charged of more than one
239 percent for all insurance policies, subscription contracts, or health care plans commencing on inception
240 or the next renewal date, based on the premium rating methodology and practices the insurer,
241 corporation, or health maintenance organization, or such governmental entity, employs; and

242 b. The Commissioner approves the certification of the actuary;

243 2. An exemption allowed under subdivision 1 shall apply for a one-year coverage period following

inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization, or such governmental entity, shall again provide coverage for behavioral health treatment required under this section;

3. An insurer, corporation, or health maintenance organization, or such governmental entity, may claim an exemption for a subsequent year, but only if the conditions specified in subdivision 1 again are met; and

4. Notwithstanding the exemption allowed under subdivision 1, an insurer, corporation, or health maintenance organization, or such a governmental entity, may elect to continue to provide coverage for behavioral health treatment required under this section.

K. Coverage for applied behavior analysis under this section will be subject to an annual maximum benefit of \$35,000, unless the insurer, corporation, or health maintenance organization elects to provide coverage in a greater amount.

L. As of January 1, 2014, to the extent that this section requires benefits that exceed the essential health benefits specified under § 1302(b) of the federal Patient Protection and Affordable Care Act (H.R. 3590), as amended (the ACA), the specific benefits that exceed the specified essential health benefits shall not be required of 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 ACA. Nothing in this subsection shall nullify application of this section to plans offered outside such an exchange.

§ 38.2-4300. Definitions.

As used in this chapter:

"Acceptable securities" means securities that (i) are legal investments under the laws of the Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, (iii) have a current market value of not less than \$50,000 nor more than \$500,000, and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership effected on the records of the depository and its participants pursuant to rules and procedures established by the depository.

"Basic health care services" means in and out-of-area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, *mental health and substance use disorder benefits*, and preventive health services. ~~"Basic health care services" shall also mean limited treatment of mental illness and substance abuse in accordance with such minimum standards as may be prescribed by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) of this title.~~ In the case of a health maintenance organization that has contracted with the Commonwealth to furnish basic health services to recipients of medical assistance under Title XIX of the United States Social Security Act pursuant to § 38.2-4320, the basic health services to be provided by the health maintenance organization to program recipients may differ from the basic health services required by this section to the extent necessary to meet the benefit standards prescribed by the state plan for medical assistance services authorized pursuant to § 32.1-325.

"Copayment" means an amount an enrollee is required to pay in order to receive a specific health care service.

"Deductible" means an amount an enrollee is required to pay out-of-pocket before the health care plan begins to pay the costs associated with health care services.

"Emergency services" means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate or individual or group agreement or contract issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Excess insurance" or "stop loss insurance" means insurance issued to a health maintenance organization by an insurer licensed in the Commonwealth, on a form approved by the Commission, or a risk assumption transaction acceptable to the Commission, providing indemnity or reimbursement against

305 the cost of health care services provided by the health maintenance organization.

306 "Health care plan" means any arrangement in which any person undertakes to provide, arrange for,
307 pay for, or reimburse any part of the cost of any health care services. A significant part of the
308 arrangement shall consist of arranging for or providing health care services, including emergency
309 services and services rendered by nonparticipating referral providers, as distinguished from mere
310 indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a
311 significant part shall mean at least 90 percent of total costs of health care services.

312 "Health care services" means the furnishing of services to any individual for the purpose of
313 preventing, alleviating, curing, or healing human illness, injury, or physical disability.

314 "Health maintenance organization" means any person who undertakes to provide or arrange for one
315 or more health care plans.

316 "Limited health care services" means dental care services, vision care services, ~~mental health services,~~
317 ~~substance abuse services, pharmaceutical services,~~ and such other services as may be determined by the
318 Commission to be limited health care services. Limited health care services shall not include hospital,
319 medical, surgical, or emergency services except as such services are provided incident to the limited
320 health care services set forth in the preceding sentence.

321 "Net worth" or "capital and surplus" means the excess of total admitted assets over the total liabilities
322 of the health maintenance organization, provided that surplus notes shall be reported and accounted for
323 in accordance with guidance set forth in the National Association of Insurance Commissioners (NAIC)
324 accounting practice and procedures manuals.

325 "Nonparticipating referral provider" means a provider who is not a participating provider but with
326 whom a health maintenance organization has arranged, through referral by its participating providers, to
327 provide health care services to enrollees. Payment or reimbursement by a health maintenance
328 organization for health care services provided by nonparticipating referral providers may exceed five
329 percent of total costs of health care services, only to the extent that any such excess payment or
330 reimbursement over five percent shall be combined with the costs for services which represent mere
331 indemnification, with the combined amount subject to the combination of limitations set forth in this
332 definition and in this section's definition of health care plan.

333 "Participating provider" means a provider who has agreed to provide health care services to enrollees
334 and to hold those enrollees harmless from payment with an expectation of receiving payment, other than
335 copayments or deductibles, directly or indirectly from the health maintenance organization.

336 "Provider" or "health care provider" means any physician, hospital, or other person that is licensed or
337 otherwise authorized in the Commonwealth to furnish health care services.

338 "Subscriber" means a contract holder, an individual enrollee, or the enrollee in an enrolled family
339 who is responsible for payment to the health maintenance organization or on whose behalf such payment
340 is made.

341 **§ 38.2-4319. Statutory construction and relationship to other laws.**

342 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this
343 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
344 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,
345 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9
346 (§ 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
347 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et
348 seq.), and 5.1 (§ 38.2-1334.3 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412
349 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,
350 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,
351 38.2-3411.3, 38.2-3411.4, ~~38.2-3412.1-04~~ 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17,
352 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of
353 § 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,
354 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter
355 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and
356 Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a
357 license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and
358 regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with
359 respect to the activities of its health maintenance organization.

360 B. For plans administered by the Department of Medical Assistance Services that provide benefits
361 pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title
362 except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136,
363 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,
364 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
365 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,
366 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.), 5 (§ 38.2-1322 et seq.), and 5.1 (§ 38.2-1334.3 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.

§ 38.2-5800. Definitions.

As used in this chapter:

"Accident and sickness insurance company" means a person subject to licensing in accordance with provisions in Chapter 10 (§ 38.2-1000 et seq.) or Chapter 41 (§ 38.2-4100 et seq.) of this title seeking or having authorization (i) to issue accident and sickness insurance as defined in § 38.2-109, (ii) to issue the benefit certificates or policies of accident and sickness insurance described in § 38.2-3801, or (iii) to provide hospital, medical and nursing benefits pursuant to §§ 38.2-4116 and 38.2-4123.

"Affiliated provider" means any provider that is employed by or has entered into a contractual agreement either directly or indirectly with a health carrier to provide health care services to members of a managed care health insurance plan for which the health carrier is responsible under this chapter.

"Basic health care services" means emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiological services, *mental health and substance use disorder benefits*, and preventive health services. *"Basic health care services" shall also mean limited treatment of mental illness and substance abuse as set forth in § 38.2-3412.1 or in the case of a health maintenance organization shall be in accordance with such minimum standards set by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) of this title.*

"Copayment" means a payment required of covered persons as a condition of the receipt of specific health services.

"Covered person" means an individual, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan (MCHIP) who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to an MCHIP.

"Evidence of coverage" includes any certificate, individual or group agreement or contract or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health carrier" means an entity subject to Title 38.2 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 entity providing a plan of health insurance, health benefits or health services, an accident and sickness insurance company, a health maintenance organization, or a nonstock corporation offering or administering a health services plan, a hospital services plan, or a medical or surgical services plan, or operating a plan subject to regulation under Chapter 45 (§ 38.2-4500 et seq.) of this title.

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

"Limited health care services" means dental care services, vision care services, ~~mental health services,~~

428 substance abuse services, pharmaceutical services, and such other services as may be determined by the
429 Commission to be limited health care services. Limited health care services shall not include hospital,
430 medical, surgical or emergency services except as such services are provided incident to the limited
431 health care services set forth in the preceding sentence.

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

448 "Medical necessity" or "medically necessary" means appropriate and necessary health care services
449 which are rendered for any condition which, according to generally accepted principles of good medical
450 practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related
451 condition, and are not provided only as a convenience.

452 "Network" means the set of providers directly or indirectly managed, owned, under contract with or
453 employed directly or indirectly by a health carrier for the purpose of delivering health care services to
454 the covered persons of an MCHIP.

455 "Provider" or "health care provider" means any hospital, physician, or other person authorized by
456 statute, licensed or certified to furnish health care services.

457 "Service area" means a clearly defined geographic area in which a health carrier has directly or
458 indirectly arranged for the provision of health care services to be generally available and readily
459 accessible to covered persons of an MCHIP.

460 **2. That § 38.2-3412.1:01 of the Code of Virginia is repealed.**

461 **3. That each insurer proposing to issue individual or group accident and sickness insurance**
462 **policies providing hospital, medical and surgical or major medical coverage on an**
463 **expense-incurred basis, corporation providing individual or group accident and sickness**
464 **subscription contracts, and health maintenance organization providing a health care plan for**
465 **health care services, whose policy, contract or plan provides coverage for mental health and**
466 **substance use disorder benefits pursuant to § 38.2-3412.1 of the Code of Virginia, shall provide to**
467 **the State Corporation Commission's Bureau of Insurance, in such format and on such schedule as**
468 **the Bureau directs, information regarding the rates at which claims for mental health and**
469 **substance use disorder benefits are denied under each policy, contract, or plan provided by it in**
470 **the Commonwealth. The Bureau shall (i) compile such information in a manner that ensures the**
471 **confidentiality of individuals who claimed, received, or were denied such benefits and (ii) make**
472 **annual reports summarizing the results of its compilations available to the public by, among such**
473 **other means as the Bureau finds to be appropriate, posting the reports on the Bureau's Internet**
474 **website. The reports shall (i) be written in nontechnical, readily understandable language, using**
475 **words of common everyday usage, that complies with the readability requirements of subsection F**
476 **of § 38.2-3735 of the Code of Virginia and (ii) provide residents of the Commonwealth with the**
477 **means to compare the rates at which each insurer, corporation, or health maintenance**
478 **organization, for each of its policies, contracts, and plans offered in the Commonwealth, has**
479 **denied claims for mental health and substance use disorder benefits.**