18102939D

HOUSE BILL NO. 583

Offered January 10, 2018

Prefiled January 8, 2018

A BILL to amend and reenact §§ 2.2-3705.5, 38.2-4214, and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 34 of Title 38.2 an article numbered 8, consisting of sections numbered 38.2-3461 through 38.2-3473, relating to premium security; reinsurance program for eligible health carriers; Virginia Health Reinsurance Association established; special fund established; federal waiver application.

Patron—Bloxom

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-3705.5, 38.2-4214, and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 34 of Title 38.2 an article numbered 8, consisting of sections numbered 38.2-3461 through 38.2-3473, as follows:

§ 2.2-3705.5. Exclusions to application of chapter; health and social services records.

The following information contained in a public record is excluded from the mandatory disclosure provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law. Redaction of information excluded under this section from a public record shall be conducted in accordance with § 2.2-3704.01.

1. Health records, except that such records may be personally reviewed by the individual who is the subject of such records, as provided in subsection F of § 32.1-127.1:03.

Where the person who is the subject of health records is confined in a state or local correctional facility, the administrator or chief medical officer of such facility may assert such confined person's right of access to the health records if the administrator or chief medical officer has reasonable cause to believe that such confined person has an infectious disease or other medical condition from which other persons so confined need to be protected. Health records shall only be reviewed and shall not be copied by such administrator or chief medical officer. The information in the health records of a person so confined shall continue to be confidential and shall not be disclosed by the administrator or chief medical officer of the facility to any person except the subject or except as provided by law.

Where the person who is the subject of health records is under the age of 18, his right of access may be asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental rights have been terminated, a court of competent jurisdiction has restricted or denied such access, or a parent has been denied access to the health record in accordance with § 20-124.6. In instances where the person who is the subject thereof is an emancipated minor, a student in a public institution of higher education, or is a minor who has consented to his own treatment as authorized by § 16.1-338 or 54.1-2969, the right of access may be asserted by the subject person.

For the purposes of this chapter, statistical summaries of incidents and statistical data concerning abuse of individuals receiving services compiled by the Commissioner of Behavioral Health and Developmental Services shall be disclosed. No such summaries or data shall include any information that identifies specific individuals receiving services.

2. Applications for admission to examinations or for licensure and scoring records maintained by the Department of Health Professions or any board in that department on individual licensees or applicants; information required to be provided to the Department of Health Professions by certain licensees pursuant to § 54.1-2506.1; information held by the Health Practitioners' Monitoring Program Committee within the Department of Health Professions that identifies any practitioner who may be, or who is actually, impaired to the extent that disclosure is prohibited by § 54.1-2517; and information relating to the prescribing and dispensing of covered substances to recipients and any abstracts from such information that are in the possession of the Prescription Monitoring Program (Program) pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 and any material relating to the operation or security of the Program.

3. Reports, documentary evidence, and other information as specified in §§ 51.5-122 and 51.5-141 and Chapter 1 (§ 63.2-100 et seq.) of Title 63.2 and information and statistical registries required to be kept confidential pursuant to Chapter 1 (§ 63.2-100 et seq.) of Title 63.2.

4. Investigative notes; proprietary information not published, copyrighted or patented; information obtained from employee personnel records; personally identifiable information regarding residents, clients or other recipients of services; other correspondence and information furnished in confidence to

the Department of Social Services in connection with an active investigation of an applicant or licensee pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2; and information furnished to the Office of the Attorney General in connection with an investigation or litigation pursuant to Article 19.1 (§ 8.01-216.1 et seq.) of Chapter 3 of Title 8.01 and Chapter 9 (§ 32.1-310 et seq.) of Title 32.1. However, nothing in this subdivision shall prevent the disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information, or other individuals involved in the investigation.

5. Information collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Services System and Services pursuant to Article 2.1 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1.

6. Reports and court documents relating to involuntary admission required to be kept confidential pursuant to § 37.2-818.

7. Information acquired (i) during a review of any child death conducted by the State Child Fatality Review team established pursuant to § 32.1-283.1 or by a local or regional child fatality review team to the extent that such information is made confidential by § 32.1-283.2; (ii) during a review of any death conducted by a family violence fatality review team to the extent that such information is made confidential by § 32.1-283.3; or (iii) during a review of any adult death conducted by the Adult Fatality Review Team to the extent made confidential by § 32.1-283.5 or by a local or regional adult fatality review team to the extent that such information is made confidential by § 32.1-283.6.

8. Patient level data collected by the Board of Health and not yet processed, verified, and released, pursuant to § 32.1-276.9, to the Board by the nonprofit organization with which the Commissioner of Health has contracted pursuant to § 32.1-276.4.

9. Information relating to a grant application, or accompanying a grant application, submitted to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Article 12 (§ 51.5-178 et seq.) of Chapter 14 of Title 51.5 that would (i) reveal (a) medical or mental health records or other data identifying individual patients or (b) proprietary business or research-related information produced or collected by the applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical, or scholarly issues, when such information has not been publicly released, published, copyrighted, or patented, and (ii) be harmful to the competitive position of the applicant.

10. Any information copied, recorded, or received by the Commissioner of Health in the course of an examination, investigation, or review of a managed care health insurance plan licensee pursuant to §§ 32.1-137.4 and 32.1-137.5, including books, records, files, accounts, papers, documents, and any or all computer or other recordings.

11. Records of the Virginia Birth-Related Neurological Injury Compensation Program required to be kept confidential pursuant to § 38.2-5002.2.

12. Information held by the State Health Commissioner relating to the health of any person subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1. However, nothing in this subdivision shall be construed to prevent the disclosure of statistical summaries, abstracts, or other information in aggregate form.

13. The names and addresses or other contact information of persons receiving transportation services from a state or local public body or its designee under Title II of the Americans with Disabilities Act, (42 U.S.C. § 12131 et seq.) or funded by Temporary Assistance for Needy Families (TANF) created under § 63.2-600.

14. Information held by certain health care committees and entities that may be withheld from discovery as privileged communications pursuant to § 8.01-581.17.

15. Data and information specified in § 37.2-308.01 relating to proceedings provided for in Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 and Chapter 8 (§ 37.2-800 et seq.) of Title 37.2.

16. (Contingent effective date) Records of and information held by the Emergency Department Care Coordination Program required to be kept confidential pursuant to § 32.1-372.

17. Data, records, and information held by the Virginia Health Reinsurance Association related to reinsurance payments paid to or requested by eligible health carriers, including incurred claims costs for enrolled individuals, pursuant to the Premium Security Plan established pursuant to Article 8 (§ 38.2-3461 et seq.) of Chapter 34 of Title 38.2.

Article 8.

Premium Security Plan.

§ 38.2-3461. Definitions.

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

"Affordable Care Act" 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.

"Association" means the Virginia Health Reinsurance Association created under § 38.2-3462.

"Attachment point" means an amount as provided in subsection B of § 38.2-3465.

"Benefit year" means the calendar year for which an eligible health carrier contracts or offers to provide a health benefit plan providing individual health insurance coverage through an exchange.

"Board" means the board of directors of the Association.

"Coinsurance rate" means the rate as provided in subsection C of § 38.2-3465.

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

"Eligible health carrier" means a health carrier that contracts or offers to provide a health benefit plan providing individual health insurance coverage through an exchange.

"Enrolled individual" means a policyholder, subscriber, enrollee, participant, covered dependent, or other individual covered by a health benefit plan providing individual health insurance coverage.

"Exchange" means a health benefit exchange established or operated in the Commonwealth, including a health benefit exchange established or operated by the U.S. Secretary of Health and Human Services, pursuant to § 1311(b) of the Affordable Care Act.

"Fund" means the Premium Security Plan Fund established pursuant to § 38.2-3471.

"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 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.

"Individual health insurance coverage" means coverage for health care services under a health benefit plan sold in the individual market.

"Individual market" means the market for individual health insurance coverage offered on an exchange.

"Member" means an eligible health carrier that is a member of the Association.

"Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the Plan.

"Plan" means the state-based reinsurance program established pursuant to this article and referred to in this article as the Premium Security Plan.

"Reinsurance cap" means the threshold amount as provided in subsection D of § 38.2-3465.

"Reinsurance payments" means an amount paid by the Association to an eligible health carrier under the Plan.

§ 38.2-3462. Virginia Health Reinsurance Association established; purposes; powers; memberships; accounts; supervision.

A. The Virginia Health Reinsurance Association is hereby established as a nonprofit legal entity. All eligible health carriers shall be and remain members of the Association as a condition of their license to transact the business of insurance in the Commonwealth. The Association shall perform the functions assigned to it under this article and shall exercise its powers through the Board established under subsection B. The Association shall come under the immediate supervision of the Commission and shall be subject to the applicable provisions of the insurance laws of the Commonwealth.

B. The board of directors of the Association shall consist of nine members as follows: six directors selected by members, subject to approval by the Commission, one of which shall be a health actuary; one director selected by the Commissioner, subject to approval by the Commission, who represents hospitals in the Commonwealth; one director selected by the Commissioner, subject to approval by the Commission, who represents health care providers in the Commonwealth; and one director selected by the Commissioner, subject to approval by the Commission, who represents licensed health insurance agents. In approving directors of the Board, the Commission shall consider, among other things, whether (i) all types of members are fairly represented and (ii) all geographic areas of the Commonwealth are fairly represented. Vacancies on the Board shall be filled for the remainder of the term by a majority vote of the remaining board members, subject to the approval of the Commission. Members of the Board may be reimbursed from moneys of the Association for expenses incurred by them as directors but shall not be otherwise compensated by the Association for their services.

C. In addition to the powers and duties enumerated in other provisions of this article, the Association shall have the power to:

1. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article;

2. Sue or be sued and to settle any claims or potential claims against it;

3. Borrow money to effect the purposes of this article;

4. Employ or retain such persons as are necessary or appropriate to perform the functions that become necessary or proper under this article;

5. Organize itself as a corporation or in other legal form permitted by the laws of the Commonwealth;

6. Establish and operate the Plan as provided in this article;

7. Establish administrative and accounting procedures for the operation of the Association;

8. Provide for the reinsuring of risks incurred as a result of members' issuing individual health insurance coverages pursuant to the Plan;

9. Provide for the administration by the Association of policies that are reinsured pursuant to subdivision 8; and

10. Take other necessary or appropriate action to discharge its duties and obligations under this article or to exercise its powers under this article.

D. Any action of the Board or the Association may be appealed to the Commission by any member if the appeal is taken within 30 days of the action being appealed. Any final action or order of the Commission shall be subject to judicial review in accordance with the provisions of §§ 12.1-39, 12.1-40, and 12.1-41.

E. The Association shall be exempt from the payment of all fees and all taxes levied by the Commonwealth or any of its subdivisions, except taxes levied on real and personal property.

F. All members shall maintain their membership in the Association as a condition of conducting the business of insurance in the Commonwealth.

G. The Association shall submit its articles, bylaws, and operating rules to the Commission for approval.

H. All meetings of the Association, its Board, and any committees of the Association shall be subject to the applicable provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

I. The Association shall be subject to examination and regulation by the Commission. The Board shall submit to the Commission, not later than each May 1, a financial report for the preceding calendar year in a form approved by the Commission and a report of its activities during the preceding calendar year. Upon the request of a member, the Association shall provide the member with a copy of the report.

J. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member or its agents or employees, the Association or its agents or employees, members of the Board, or the Commission or its representatives for any action taken by them in the performance of their powers and duties under this article. This immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

§ 38.2-3463. Premium calculations.

The Commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Plan had not been established. Each eligible health carrier shall submit this information as part of its rate filing. The Commissioner shall consider this information as part of the rate review pursuant to § 38.2-316.1.

§ 38.2-3464. Premium Security Plan; duties of Association.

A. The Association is designated as the reinsurance entity to administer the state-based reinsurance program referred to as the Premium Security Plan.

B. The Association is authorized to apply for any available federal funding for the Plan. All funds received by or appropriated to the Association shall be deposited in the Fund.

C. The Association shall collect or access such data from an eligible health carrier as is necessary to determine reinsurance payments, in accordance to the requirements of subsection C of § 38.2-3468.

D. For each applicable benefit year, the Association shall notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

E. On a quarterly basis during the applicable benefit year, the Association shall provide each eligible health carrier with the calculation of total reinsurance payment requests.

F. By August 15 of the year following the applicable benefit year, the Association shall disburse all applicable reinsurance payments to an eligible health carrier.

§ 38.2-3465. Payment parameters.

A. The Board shall establish payment parameters that:

1. Stabilize or reduce premium rates in the individual market;

2. Increase participation in the individual market;

3. Improve access to health care services and their providers for enrolled individuals;

4. Mitigate the impact high-risk individuals have on premium rates in the individual market;

5. Take into account any federal funding available for the Plan; and

6. Take into account the total amount available to fund the Plan.

B. The attachment point for the Plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point for 2020 shall be $50,000. The attachment point for following years shall be set by the Board at a minimum of $50,000, provided that the attachment point shall not exceed the reinsurance cap.

C. The coinsurance rate for the Plan is the rate at which the Association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate for 2020 shall be 80 percent. The coinsurance rate for following years shall be set by the Board at a rate between 50 and 80 percent.

D. The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap for 2020 shall be $250,000. The reinsurance cap for following years shall be set by the Board at an amount not exceeding $250,000.

E. The Board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request submitted pursuant to § 38.2-3472.

§ 38.2-3466. Approval of payment parameters.

A. For 2021 and following years, the Board shall propose to the Commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The Commissioner shall approve or reject the payment parameters no later than 14 days following the Board's proposal. If the Commissioner fails to approve or reject the payment parameters within 14 days following receipt of the Board's proposal, the proposed payment parameters shall be deemed approved.

B. If the moneys in the Fund are not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the Board, in consultation with the Commissioner, shall propose payment parameters within the available funding. The Commissioner shall permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

§ 38.2-3467. Calculation of reinsurance payments.

A. Each reinsurance payment shall be calculated with respect to an eligible health carrier's incurred claims costs for an enrolled individual's covered benefits in the applicable benefit year. If such incurred claims costs for an enrolled individual do not exceed the attachment point, the reinsurance payment is $0. If such incurred claims costs for an enrolled individual exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of (i) the claims costs minus the attachment point or (ii) the reinsurance cap minus the attachment point.

B. The Board shall ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid for an eligible claim by the eligible health carrier. "Total amount paid for an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or copayment, as of the time the data are submitted or made accessible under subsection C of § 38.2-3468.

§ 38.2-3468. Requests for reinsurance payments; data submissions.

A. An eligible health carrier may request reinsurance payments from the Association when the eligible health carrier meets the requirements of this section and § 38.2-3467.

B. An eligible health carrier's request for reinsurance payments shall comply with any requirements established by the Board.

C. An eligible health carrier's request for reinsurance payment shall (i) provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under 42 U.S.C. § 18063 and (ii) include an attestation to the Board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

D. An eligible health carrier shall provide the access described in subsection C for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

E. An eligible health carrier shall maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this article for a period of at least six years. An eligible health carrier shall also make those documents and records available upon request from the Commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

F. The Association may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this article. The eligible health carrier shall ensure that its contractors, subcontractors, and agents cooperate with any audit conducted under this article. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this article, the eligible health carrier may provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes

a finding of material weakness or significant deficiency, the eligible health carrier shall:

1. Provide a written corrective action plan to the Association for approval;

2. Implement the approved corrective action plan; and

3. Provide the Association with written documentation of the corrective action once taken.

§ 38.2-3469. Confidentiality of data.

A. Data and information collected or held by the Association or the Commission under this article shall be exempt from mandatory disclosure as provided in subdivision 17 of § 2.2-3705.5.

B. Data and information that an eligible health carrier considers confidential proprietary information that is provided to the Association or the Commission pursuant to the provisions of this article shall be excluded from, and the Commission shall not be subject to, subpoena or public inspection with respect to such information as provided in § 38.2-221.1.

§ 38.2-3470. Accounting, reports, and audits of the Association.

A. The Board shall keep an accounting for each benefit year of all:

1. Funds appropriated for reinsurance payments and administrative and operational expenses;

2. Requests for reinsurance payments received from eligible health carriers;

3. Reinsurance payments made to eligible health carriers; and

4. Administrative and operational expenses incurred for the Plan.

B. The Board shall submit to the Commissioner and make available to the public a report summarizing the operations of the Plan for each benefit year by posting the summary on the Commission's website and making the summary otherwise available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

C. The Plan is subject to audit by the Auditor of Public Accounts. The Board shall ensure that the Association's contractors, subcontractors, and agents cooperate with the audit.

D. An independent certified public accountant selected by the Board shall annually audit the accounts of the Plan. The cost of such audit services shall be borne by the Plan and be paid from moneys designated for such purposes in the Fund. The audit shall be performed at least each fiscal year, in accordance with generally accepted auditing standards and, accordingly, include such tests of the accounting records and such auditing procedures as considered necessary under the circumstances.

E. The Board shall:

1. Provide a written corrective action plan to the Commissioner for approval within 60 days of the completed audit;

2. Implement the corrective action plan; and

3. Provide the Commissioner with written documentation of the corrective actions taken.

F. By December 1 of each year, the Board shall submit a report to the Chairs of the House Committee on Commerce and Labor and the Senate Committee on Commerce and Labor regarding any finding of material weakness or significant deficiency found in an audit conducted pursuant to this section.

§ 38.2-3471. Premium Security Plan Fund.

There is hereby created in the state treasury a special nonreverting fund to be known as the Premium Security Plan Fund, referred to in this article as "the Fund." The Fund shall be established on the books of the Comptroller. All funds appropriated for such purpose, and funds provided to the Commonwealth pursuant to the state innovation waiver requested pursuant to § 38.2-3472, and any gifts, donations, grants, bequests, and other funds received on its behalf shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes of paying the operational and administrative costs of the Plan and reinsurance payments to eligible health carriers authorized pursuant to this article. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the chairman of the Board and the Commissioner or his designee.

§ 38.2-3472. State innovation waiver request.

A. The Commissioner shall apply to the U.S. Secretary of Health and Human Services under 42 U.S.C. § 18052 for a state innovation waiver to implement the Plan for benefit years beginning January 1, 2020, and future years, to maximize federal funding. The waiver application shall clearly state that operation of the Plan is contingent on approval of the waiver request.

B. The Commissioner shall submit the waiver application to the U.S. Secretary of Health and Human Services by January 1, 2019. The Commissioner shall make a draft application available for public review and comment by September 1, 2018. The Commissioner shall promptly notify the Board and the Chairs of the House Committees on Commerce and Labor and Appropriations and the Senate Committees on Commerce and Labor and Finance of any federal actions regarding the waiver request.

§ 38.2-3473. Plan contingent on approval of federal waiver.

If the state innovation waiver request submitted pursuant to § 38.2-3472 is not approved, the Association and its Board shall not administer the Plan or provide reinsurance payments to eligible health carriers.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 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, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3454, *Article 8 (§ 38.2-3461 et seq.) of Chapter 34, §§* 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 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.), §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

§ 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, 38.2-325, 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.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 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 38.2-3407.19, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 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, *Article 8 (§ 38.2-3461 et seq.) of Chapter 34, §* 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, 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, 38.2-325, 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.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 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 the provisions of this act, other than § 38.2-3472 of the Code of Virginia, as created by this act, shall become effective 30 days following the date the Commissioner of Insurance notifies the Governor and the Chairs of the House Committees on Appropriations and Commerce and Labor and the Senate Committees on Finance and Commerce and Labor of federal approval of the state innovation request required to be submitted by the Commissioner of Insurance pursuant to § 38.2-3472 of the Code of Virginia, as created by this act.