

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 2.1-20.1 as it is currently effective and as it may become effective and §§ 32.1-325 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.3, relating to health and related insurance for state employees, State Plan for Medical Assistance Services, accident and sickness insurance; minimum hospital stay for mastectomy and certain lymph node dissection patients.

[H 542]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 2.1-20.1 as it is currently effective and as it may become effective and §§ 32.1-325 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.3 as follows:

§ 2.1-20.1. Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits 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.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. Such appeals process shall include a separate expedited emergency appeals procedure which shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care.

5. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services shall mean those services designed to help an

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individual attain or retain the capability to function age-appropriately within his environment, and shall include services which enhance functional ability without effecting a cure.

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

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

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

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

9. Include coverage providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and beneficiaries thereof. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

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

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

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

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

§ 2.1-20.1. (Delayed effective date) Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state

employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits 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.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. Such appeals process shall include a separate expedited emergency appeals procedure which shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care.

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

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

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

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

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

9. Include coverage providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

179 C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from
 180 such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be
 181 deposited in the employee health insurance fund, from which payments for claims, premiums, cost
 182 containment programs and administrative expenses shall be withdrawn from time to time. The funds of
 183 the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from
 184 all other funds of the Commonwealth, and shall be invested and administered solely in the interests of
 185 the employees and beneficiaries thereof. Neither the General Assembly nor any public officer, employee,
 186 or agency shall use or authorize the use of such trust funds for any purpose other than as provided in
 187 law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight
 188 of the health insurance fund.

189 D. For the purposes of this section:

190 "Peer-reviewed medical literature" means a scientific study published only after having been critically
 191 reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal
 192 that has been determined by the International Committee of Medical Journal Editors to have met the
 193 Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical
 194 literature does not include publications or supplements to publications that are sponsored to a significant
 195 extent by a pharmaceutical manufacturing company or health carrier.

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

199 "State employee" means state employee as defined in § 51.1-124.3, employee as defined in
 200 § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301
 201 and judges, clerks and deputy clerks of district courts of the Commonwealth, interns and residents
 202 employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents,
 203 and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.15:25.

204 E. Provisions shall be made for retired employees to obtain coverage under the above plan. The
 205 Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

206 F. Any self-insured group health insurance plan established by the Department of Personnel and
 207 Training which utilizes a network of preferred providers shall not exclude any physician solely on the
 208 basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets
 209 the plan criteria established by the Department.

210 § 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human
 211 Services pursuant to federal law; administration of plan; contracts with health care providers.

212 A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to
 213 time and submit to the Secretary of the United States Department of Health and Human Services a state
 214 plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and
 215 any amendments thereto. The Board shall include in such plan:

216 1. A provision for payment of medical assistance on behalf of individuals, up to the age of
 217 twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as
 218 child-placing agencies by the Department of Social Services or placed through state and local subsidized
 219 adoptions to the extent permitted under federal statute;

220 2. A provision for determining eligibility for benefits for medically needy individuals which
 221 disregards from countable resources an amount not in excess of \$2,500 for the individual and an amount
 222 not in excess of \$2,500 for his spouse when such resources have been set aside to meet the burial
 223 expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value
 224 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender
 225 value of such policies has been excluded from countable resources and (ii) the amount of any other
 226 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of
 227 meeting the individual's or his spouse's burial expenses;

228 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically
 229 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the
 230 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used
 231 as the principal residence and all contiguous property. For all other persons, a home shall mean the
 232 house and lot used as the principal residence, as well as all contiguous property, as long as the value of
 233 the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the
 234 definition of home as provided here is more restrictive than that provided in the state plan for medical
 235 assistance in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used
 236 as the principal residence and all contiguous property essential to the operation of the home regardless
 237 of value;

238 4. A provision for payment of medical assistance on behalf of individuals up to the age of
 239 twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of

twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment 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. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma or breast cancer and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Regulations to implement this provision shall be effective in 280 days or less of the enactment of this subdivision. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process; and

8. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance; and

9. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

In preparing the plan, the Board shall work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured. The Board shall also initiate such cost containment or other measures as are set forth in the appropriations act. The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

The Board's regulations shall incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

B. The Director of Medical Assistance Services is authorized to administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

C. The Director of Medical Assistance Services is authorized to enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not

301 appealed, or if it is not reversed upon appeal.

302 The Director may refuse to enter into or renew an agreement or contract with any provider which
303 has been convicted of a felony. In addition, the Director may refuse to enter into or renew an agreement
304 or contract with a provider who is or has been a principal in a professional or other corporation when
305 such corporation has been convicted of a felony.

306 In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his
307 interest in a convicted professional or other corporation, the Director shall, upon request, conduct a
308 hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's
309 participation in the conduct resulting in the conviction.

310 The Director's decision upon reconsideration shall be consistent with federal and state laws. The
311 Director may consider the nature and extent of any adverse impact the agreement or contract denial or
312 termination may have on the medical care provided to Virginia Medicaid recipients.

313 When the services provided for by such plan are services which a clinical psychologist or a clinical
314 social worker or licensed professional counselor or clinical nurse specialist is licensed to render in
315 Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical
316 social worker or licensed professional counselor or licensed clinical nurse specialist who makes
317 application to be a provider of such services, and thereafter shall pay for covered services as provided in
318 the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists,
319 licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at
320 rates based upon reasonable criteria, including the professional credentials required for licensure. These
321 regulations shall be effective within 280 days of July 1, 1996. The Board shall promulgate regulations
322 for the reimbursement of licensed clinical nurse specialists to be effective within 280 days of the
323 enactment of this provision.

324 D. The Board shall prepare and submit to the Secretary of the United States Department of Health
325 and Human Services such amendments to the state plan for medical assistance as may be permitted by
326 federal law to establish a program of family assistance whereby children over the age of eighteen years
327 shall make reasonable contributions, as determined by regulations of the Board, toward the cost of
328 providing medical assistance under the plan to their parents.

329 E. The Director is authorized to negotiate and enter into agreements for services rendered to eligible
330 recipients with special needs. The Board shall promulgate regulations regarding these special needs
331 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special
332 needs as defined by the Board.

333 Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act
334 (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by this subsection.
335 Agreements made pursuant to this subsection shall comply with federal law and regulation.

336 § 38.2-3418.3. *Minimum hospital stay for mastectomy and certain lymph node dissection patients.*

337 A. *Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or*
338 *group accident and sickness insurance policies providing hospital, medical and surgical, or major*
339 *medical coverage on an expense-incurred basis; each corporation providing individual or group*
340 *accident and sickness subscription contracts; and each health maintenance organization providing a*
341 *health care plan for health care services shall provide coverage providing a minimum stay in the*
342 *hospital of not less than forty-eight hours for a patient following a radical or modified radical*
343 *mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or a*
344 *partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this*
345 *section shall be construed as requiring the provision of inpatient coverage where the attending physician*
346 *in consultation with the patient determines that a shorter period of hospital stay is appropriate. Such*
347 *provision shall be included under any policy, contract or plan delivered, issued for delivery or renewed*
348 *in this Commonwealth on and after July 1, 1998.*

349 *The provisions of this section shall not apply to short-term travel, accident only, limited or specified*
350 *disease policies, policies or contracts designed for issuance to persons eligible for coverage under Title*
351 *XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or*
352 *federal governmental plans, or to short-term nonrenewable policies of not more than six months'*
353 *duration.*

354 § 38.2-4319. Statutory construction and relationship to other laws.

355 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this
356 chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229,
357 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through
358 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2
359 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, §§ 38.2-1800 through 38.2-1836,
360 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10,
361 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, ~~38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, through~~

38.2-3418.3, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 54 (§ 38.2-5400 et seq.) of this title 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.) of this title except with respect to the activities of its health maintenance organization.

B. 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.

C. 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.

D. 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.