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SENATE BILL NO. 1235

FLOOR AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by Senator Woods)

(Patron Prior to Substitute—Senator Williams)

Senate Amendments in [] — February 10, 1999

A *BILL to amend and reenact §§ 2.1-20.1, 32.1-137.6, 32.1-137.15, 38.2-3407.1, 38.2-3407.10, 38.2-4209, 38.2-4214, 38.2-4306.1, 38.2-4312, 38.2-4319 [and , 38.2-4509 and] 38.2-5804 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 38.2-3407.1:1, 38.2-3407.9:01, [and] 38.2-3407.11:1, [38.2-3407.13,] [and 38.2-3418.8] and by adding in Title 38.2 a chapter numbered 59, consisting of sections numbered 38.2-5900 through 38.2-5905, relating to review of adverse utilization review decisions; review of claims appeal by an independent external panel, Managed Care Ombudsman.*

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-20.1, 32.1-137.6, 32.1-137.15, 38.2-3407.1, 38.2-3407.10, 38.2-4209, 38.2-4214, 38.2-4306.1, 38.2-4312, 38.2-4319 and 38.2-5804 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding sections numbered 38.2-3407.1:1, 38.2-3407.9:01, [and] 38.2-3407.11:1, [and 38.2-3418.8] and by adding in Title 38.2 a chapter numbered 59, consisting of sections numbered 38.2-5900 through 38.2-5905 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. a. 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.

b. In order to be considered a screening mammogram for which coverage shall be made available under this section:

(1) The mammogram must be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report must be sent or delivered to the health care practitioner who ordered it;

(2) The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

(3) The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

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

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60 Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be
61 provided incorporating any changes in such Guidelines or Standards within six months of the publication
62 of such Guidelines or Standards or any official amendment thereto.

63 4. a. Include an appeals process for resolution of written complaints concerning denials or partial
64 denials of claims that shall provide reasonable procedures for resolution of such written complaints and
65 shall be published and disseminated to all covered state employees. Such appeals process shall include a
66 separate expedited emergency appeals procedure which shall provide resolution within one business day
67 of receipt of a complaint concerning situations requiring immediate medical care. *The Department shall*
68 *contract with one or more impartial health entities to review such denials or partial denials of claims.*
69 *Impartial health entities may include medical peer review organizations, independent utilization review*
70 *companies, or other health care entities which the Department shall determine to possess the necessary*
71 *credentials and otherwise to be qualified to review denials or partial denials of claims. The Department*
72 *shall adopt regulations to assure that the impartial health entity conducting the reviews have adequate*
73 *standards, credentials and experience for such review. The impartial health entity shall examine the*
74 *final denial of claims to determine whether the decision is objective, clinically valid, compatible with*
75 *established principles of health care. The decision of the impartial health entity shall (i) be in writing,*
76 *(ii) contain findings of fact as to the material issues in the case and the basis for those findings, and*
77 *(iii) be final and binding if consistent with law and policy.*

78 b. *Prior to assigning an appeal to an impartial health entity, the Department shall verify that the*
79 *impartial health entity conducting the review of a denial of claims has no relationship or association*
80 *with (i) the covered employee, (ii) the treating health care provider, or any of its employees or affiliates,*
81 *(iii) the medical care facility at which the covered service would be provided, or any of its employees or*
82 *affiliates, or (iv) the development or manufacture of the drug, device, procedure or other therapy which*
83 *is the subject of the final denial of a claim. There shall be no liability on the part of and no cause of*
84 *action shall arise against any officer or employee of an impartial health entity for any actions taken or*
85 *not taken or statements made by such officer or employee in good faith in the performance of their*
86 *powers and duties.*

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

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

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

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

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

111 9. Include coverage for equipment, supplies and outpatient self-management training and education,
112 including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using
113 diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional
114 legally authorized to prescribe such items under law. To qualify for coverage under this subdivision,
115 diabetes outpatient self-management training and education shall be provided by a certified, registered or
116 licensed health care professional.

117 10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive
118 breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy
119 performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish
120 symmetry between the two breasts. For persons previously covered under the plan, there may be no
121 denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears.

12. 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.

13. Include coverage (i) to persons age fifty and over and (ii) to persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

14. *Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the primary care provider, in consultation with the plan and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.*

15.a. *Include provisions allowing employees to continue receiving health care services for a period of up to ninety days from the date of the primary care physicians notice of termination from any of the plan's provider panels.*

b. *The plan shall notify any provider at least ninety days prior to the date of termination of the provider, except when the provider is terminated for cause.*

c. *For a period of at least ninety days from the date of the notice of a provider's termination from any of the plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the plan to render health care services to any of the covered employees who (i) were in an active course of treatment from the provider prior to the notice of termination, and (ii) request to continue receiving health care services from the provider.*

d. *Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of post-partum care directly related to the delivery.*

e. *Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the plan to continue rendering health services to any covered employee who is determined to be terminally ill (as defined under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for the remainder of the employee's life for care directly related to the treatment of the terminal illness.*

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.

G. The plan established by the Department shall include, in each planning district, at least two health coverage options, each sponsored by unrelated entities. In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan. This section shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan separate from the plan established by the Department.

H. 1. Any self-insured group health insurance plan established by the Department of Personnel that includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the plan if the formulary is developed, reviewed, and updated in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are licensed physicians.

2. If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a specific, medically necessary nonformulary prescription drug if, after reasonable investigation and consultation with the prescribing physician, the formulary drug is determined to be an inappropriate therapy for the medical condition of the person. The plan shall act on such requests within forty-eight hours of receipt of the request.

I. Any plan established by the Department of Personnel and Training requiring preauthorization prior to rendering medical treatment shall have personnel available to provide authorization at all times when such preauthorization is required.

J. Any plan established by the Department of Personnel and Training shall provide to all covered employees written notice of any benefit reductions during the contract period at least thirty days before such reductions become effective .

K. No contract between a provider and any plan established by the Department of Personnel and Training shall include provisions which include an incentive or specific payments made directly, in any form, to a health care provider or health care provider group as an inducement to deny services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a covered employees with similar medical conditions. This subsection does not prohibit the use of capitation as a method of payment, nor shall it prohibit the inclusion of provisions that include incentives or payments that reward providers or provider groups for providing services in a cost-effective manner or that promote the quality initiatives established under a managed care health insurance plan.

L. 1. The Department of Personnel and Training shall appoint an Ombudsman to promote and protect the interests of covered employees under any state employee's health plan.

2. The Ombudsman shall:

a. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.

b. Answer inquiries from covered employees by telephone and electronic mail.

- 245 c. Provide to covered employees information concerning the state health plans.
- 246 d. Develop information on the types of health plans available, including benefits and complaint
247 procedures and appeals.
- 248 e. Make available, either separately or through an existing Internet web site utilized by the
249 Department of Personnel and Training, information as set forth in subdivision d and such additional
250 information as he deems appropriate.
- 251 f. Maintain data on inquiries received, the types of assistance requested, any actions taken and the
252 disposition of each such matter.
- 253 g. Upon request, assist covered employees in using the procedures and processes available to them
254 from their health plan, including all appeal procedures. Such assistance may require the review of
255 health care records of a covered employee, which shall be done only with that employee's express
256 written consent. The confidentiality of any such medical records shall be maintained in accordance with
257 the confidentiality and disclosure laws of the Commonwealth.
- 258 h. Ensure that covered employees have access to the services provided by the Ombudsman and that
259 the covered employees receive timely responses from the Ombudsman or his representatives to the
260 inquiries.
- 261 i. Report annually on his activities to the standing committees of the General Assembly having
262 jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of
263 each year.
- 264 § 32.1-137.6. Complaint system.
- 265 A. Each managed care health insurance plan licensee subject to § 32.1-137.2 shall establish and
266 maintain for each of its managed care health insurance plans a complaint system approved by the
267 Commissioner and the Bureau of Insurance to provide reasonable procedures for the resolution of
268 written complaints in accordance with the requirements established under this article and Title 38.2, and
269 shall include the following:
- 270 1. A record of the complaints shall be maintained for the period set forth in § 32.1-137.16 for review
271 by the Commissioner.
- 272 2. Each managed care health insurance plan licensee shall provide complaint forms and/or written
273 procedures to be given to covered persons who wish to register written complaints. Such forms or
274 procedures shall include the address and telephone number of the managed care licensee to which
275 complaints shall be directed and the mailing address, telephone number, and the electronic mail address
276 of the Managed Care Ombudsman and shall also specify any required limits imposed by or on behalf of
277 the managed care health insurance plan. Such forms and written procedures shall include a clear and
278 understandable description of the covered person's right to appeal adverse decisions pursuant to
279 § 32.1-137.15.
- 280 B. The Commissioner, in cooperation with the Bureau of Insurance, shall examine the complaint
281 system. The effectiveness of the complaint system of the managed care health insurance plan licensee in
282 allowing covered persons, or their duly authorized representatives, to have issues regarding quality of
283 care appropriately resolved under this article shall be assessed by the State Health Commissioner under
284 this article. Compliance by the health carrier and its managed care health insurance plans with the terms
285 and procedures of the complaint system, as well as the provisions of Title 38.2, shall be assessed by the
286 Bureau of Insurance.
- 287 C. As part of the renewal of a certificate, each managed care health insurance plan licensee shall
288 submit to the Commissioner and to the Managed Care Ombudsman an annual complaint report in a
289 form agreed and prescribed by the Board and the Bureau of Insurance. The complaint report shall
290 include, but shall not be limited to (i) a description of the procedures of the complaint system, (ii) the
291 total number of complaints handled through the complaint system, (iii) the disposition of the complaints,
292 (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to
293 process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims
294 adjudicated during the year with respect to any of the managed care health insurance plan's health care
295 providers.
- 296 The Department of Personnel and Training and the Department of Medical Assistance Services shall
297 file similar periodic reports with the Commissioner, in a form prescribed by the Board, providing
298 appropriate information on all complaints received concerning quality of care and utilization review
299 under their respective health benefits program and managed care health insurance plan licensee
300 contractors.
- 301 D. The Commissioner shall examine the complaint system under subsection B for compliance of the
302 complaint system with respect to quality of care and shall require corrections or modifications as
303 deemed necessary.
- 304 § 32.1-137.15. Final adverse decision; appeal.
- 305 A. Each entity shall establish an appeals process, including a process for expedited appeals, to

consider any final adverse decision that is appealed by a covered person, his representative, or his provider. Except as provided in subsection E, notification of the results of the appeal process shall be provided to the appellant no later than sixty working days after receiving the required documentation. The decision shall be in writing and shall state the criteria used and the clinical reason for the decision. *If the appeal is denied, such notification shall include a clear and understandable description of the covered person's right to appeal final adverse decisions to the Bureau of Insurance in accordance with Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2, the procedures for making such an appeal, and the binding nature and effect of such an appeal, including all forms prescribed by the Bureau of Insurance pursuant to § 38.2-5901. Such notification shall also include the mailing address, telephone number, and electronic mail address of the Managed Care Ombudsman.*

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

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

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

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

E. When an adverse decision or adverse reconsideration is made and the treating health care provider believes that the decision warrants an immediate appeal, the treating health care provider shall have the opportunity to appeal the adverse decision or adverse reconsideration by telephone on an expedited basis.

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

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

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

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

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

G. No entity performing utilization review pursuant to this article or ~~Chapter 53 (§ 38.2-5300 et seq.) of Title 38.2 Article 2.1 of Chapter 5 (§ 32.1-138.6 et seq.)~~, shall terminate the employment or other contractual relationship or otherwise penalize a health care provider for advocating the interest of his patient or patients in the appeals process or invoking the appeals process, unless the provider engages in a pattern of filing appeals that are without merit.

§ 38.2-3407.1. Interest on accident and sickness claim proceeds.

A. If an action to recover the claim proceeds due under an individual or group accident and sickness policy results in a judgment against an insurer, interest on the judgment at the legal rate of interest shall be paid from the date of presentation to the insurer of proof of loss to the date judgment is entered.

~~B. If no action is brought, interest upon the claim proceeds paid to the policyholder, insured, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.~~

C. This section shall not apply to individual policies issued prior to July 1, 1990, but shall apply to

any renewals or reissues of group accident and sickness policies occurring after that date.

§ C. This section shall not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the insurer's obligation on such claims.

§ D. For purposes of this section, "proof of loss" means all necessary documentation reasonably required by the insurer to make a determination of benefit coverage.

§ 38.2-3407.1:1. Interest on accident and sickness claim proceeds; escrow accounts.

A. Within thirty working days from the insurer's receipt of proof of loss, an insurer shall (i) pay the claim or (ii) place into an interest-bearing demand escrow account, an amount equal to the insurer's usual and customary payment for the services for which the proof of loss is submitted. For purposes of this section, proof of loss shall include the identity of the patient and the health care provider, the service provided, and the date, place and cost of such service.

B. This section shall not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the insurer's obligation on such claims.

C. All interest earned from the money placed in escrow pursuant to subsection A shall be paid annually to the Virginia Indigent Health Care Trust Fund established pursuant to Chapter 11 (§ 32.1-332 et seq.) of Title 32.1. Contributions to the Virginia Indigent Health Care Trust Fund by insurers shall be made once annually in January of each calendar year beginning in January 2000. The policy and details relating to receipt of contributions shall be prescribed by the Board.

D. Any person who knowingly and willfully fails to pay in a timely manner the contribution to the Virginia Indigent Health Care Trust Fund required by this section shall be civilly liable in an amount not to exceed \$500 per incident. All penalties collected under this subsection shall be collected and remitted to the Virginia Indigent Health Care Trust Fund. The Commissioner of Insurance shall be responsible for enforcing the provisions of this section.

§ 38.2-3407.9:01. Prescription drug formularies.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the insurer, corporation, or health maintenance organization if the formulary is developed, reviewed, and updated in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are licensed physicians.

B. If an insurer, corporation, or health maintenance organization maintains one or more drug formularies, each insurer, corporation or health maintenance organization shall:

1. Disseminate to participating providers and pharmacists and to any nonpreferred or nonparticipating pharmacists as described in §§ 38.2-3407.7 and 38.2-4312.1, the complete, current drug formulary or formularies maintained by the insurer, corporation, or health maintenance organization, including a list of the prescription drugs on the formulary by major therapeutic category that specifies whether a particular prescription drug is preferred over other drugs; and

2. Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug if, after reasonable investigation and consultation with the prescribing physician, the formulary drug is determined to be an inappropriate therapy for the medical condition of the enrollee. The insurer, corporation or health maintenance organization shall act on such requests within forty-eight hours of receipt of the request.

§ 38.2-3407.10. Health care provider panels.

A. As used in this section:

"Carrier" means:

1. Any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;

2. Any corporation providing individual or group accident and sickness subscription contracts;

3. Any health maintenance organization providing health care plans for health care services;

4. Any corporation offering prepaid dental or optometric services plans; or

5. Any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

"Enrollee" means any person entitled to health care services from a carrier.

"Provider" means a hospital, physician or any type of provider licensed, certified or authorized by statute to provide a covered service under the health benefit plan.

429 "Provider panel" means those providers with which a carrier contracts to provide health care services
430 to the carrier's enrollees under the carrier's health benefit plan. However, such term does not include an
431 arrangement between a carrier and providers in which any provider may participate solely on the basis
432 of the provider's contracting with the carrier to provide services at a discounted fee-for-service rate.

433 B. Any such carrier which offers a provider panel shall establish and use it in accordance with the
434 following requirements:

435 1. Notice of the development of a provider panel in the Commonwealth or local service area shall be
436 filed with the Department of Health Professions.

437 2. Carriers shall provide a provider application and the relevant terms and conditions to a provider
438 upon request.

439 C. A carrier that uses a provider panel shall establish procedures for:

440 1. Notifying an enrollee of:

441 a. The termination from the carrier's provider panel of the enrollee's primary care provider who was
442 furnishing health care services to the enrollee; and

443 b. The right of an enrollee upon request to continue to receive health care services for a period of up
444 to ~~sixty~~ *ninety* days from the date of the primary care provider's notice of termination from a carrier's
445 provider panel, except when a provider is terminated for cause.

446 2. Notifying a provider at least ~~sixty~~ *ninety* days prior to the date of the termination of the provider,
447 except when a provider is terminated for cause.

448 3. Providing reasonable notice to primary care providers in the carrier's provider panel of the
449 termination of a specialty referral services provider.

450 4. Notifying the purchaser of the health benefit plan, whether such purchaser is an individual or an
451 employer providing a health benefit plan, in whole or in part, to its employees and enrollees of the
452 health benefit plan of:

453 a. A description of all types of payment arrangements that the carrier uses to compensate providers
454 for health care services rendered to enrollees, including, but not limited to, withholds, bonus payments,
455 capitation and fee-for-service discounts; and

456 b. The terms of the plan in clear and understandable language which reasonably informs the
457 purchaser of the practical application of such terms in the operation of the plan.

458 D. Whenever a provider voluntarily terminates his contract with a carrier to provide health care
459 services to the carrier's enrollees under a health benefit plan, he shall furnish reasonable notice of such
460 termination to his patients who are enrollees under such plan.

461 E. A carrier may not deny an application for participation or terminate participation on its provider
462 panel on the basis of gender, race, age, religion or national origin.

463 F. 1. For a period of at least ~~sixty~~ *ninety* days from the date of the notice of a provider's termination
464 from the carrier's provider panel, except when a provider is terminated for cause, the provider shall be
465 permitted by the carrier to render health care services to any of the carrier's enrollees who:

466 a. Were in an active course of treatment from the provider prior to the notice of termination; and

467 b. Request to continue receiving health care services from the provider.

468 2. *Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to*
469 *continue rendering health services to any enrollee who has entered the second trimester of pregnancy at*
470 *the time of a provider's termination of participation, except when a provider is terminated for cause.*
471 *Such treatment shall, at the enrollee's option, continue through the provision of post-partum care*
472 *directly related to the delivery.*

473 3. *Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to*
474 *continue rendering health services to any enrollee who is determined to be terminally ill (as defined*
475 *under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of*
476 *participation, except when a provider is terminated for cause. Such treatment shall, at the enrollee's*
477 *option, continue for the remainder of the enrollee's life for care directly related to the treatment of the*
478 *terminal illness.*

479 24. A carrier shall reimburse a provider under this subsection in accordance with the carrier's
480 agreement with the providers.

481 G. 1. A carrier shall provide to a purchaser prior to enrollment and to existing enrollees at least once
482 a year a list of members in its provider panel, which list shall also indicate those providers who are not
483 currently accepting new patients.

484 2. The information provided under subdivision 1 shall be updated at least once a year.

485 H. No contract between a carrier and a provider may require that the provider indemnify the carrier
486 for the carrier's negligence, willful misconduct, or breach of contract, if any.

487 I. No contract between a carrier and a provider shall require a provider, as a condition of
488 participation on the panel, to waive any right to seek legal redress against the carrier.

489 J. No contract between a carrier and a provider shall prohibit, impede or interfere in the discussion
490 of medical treatment options between a patient and a provider.

K. A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

L. Any carrier requiring preauthorization prior to rendering medical treatment shall have personnel available to provide such authorization at all times when such preauthorization is required.

M. Carriers shall provide to their group policyholders written notice of any benefit reductions during the contract period at least sixty days before such benefit reductions become effective. Group policyholders shall, in turn, provide to their enrollees written notice of any benefit reductions during the contract period at least thirty days before such benefit reductions become effective.

N. No contract between a provider and a carrier shall include provisions which include an incentive or specific payments made directly, in any form, to a health care provider or health care provider group as an inducement to deny services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions. This subsection does not prohibit the use of capitation as a method of payment, nor shall it prohibit the inclusion of provisions that include incentives or payments that reward providers or provider groups for providing services in a cost-effective manner or that promote the quality initiatives established under a managed care health insurance plan.

EO. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

MP. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on or after July 1, 1996, or at any time after the effective date hereof when any term of any such policy, contract, or plan is changed or any premium adjustment is made. In addition, the requirements of this section shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1996. However, the ninety day period referred to in subdivision C 1 b and C 2 of this section shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1999, the requirements set forth in subdivisions F 2 and F 3 shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1999, and the requirements set forth in subsections L, M, and N shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1999.

§ 38.2-3407.11:1. Access to specialists; standing referrals.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services shall permit any individual covered thereunder direct access, as provided in subsection B, to the health care services of a participating specialist (i) authorized to provide services under such policy, contract or plan and (ii) selected by such individual.

B. An insurer, corporation, or health maintenance organization, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to a specialist. For the purposes of this section, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time.

C. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize.

D. An insurer, corporation, or health maintenance organization in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the plan or issuer, or if the primary care provider in consultation with the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist.

E. Nothing contained herein shall prohibit an insurer, corporation, or health maintenance organization from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

F. Each insurer, corporation or health maintenance organization subject to the provisions of this

552 section shall inform subscribers of the provisions of this section. Such notice shall be provided in
553 writing.

554 G. The requirements of this section shall apply to all insurance policies, contracts, and plans
555 delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such
556 policy, contract, or plan is changed or any premium adjustment is made. The provisions of this section
557 shall not apply to short-term travel or accident-only policies, to short-term nonrenewable policies of not
558 more than six months' duration, or policies or contracts issued to persons eligible under Title XVIII of
559 the Social Security Act, known as Medicare, or any other similar coverage under state or federal
560 governmental plans.

561 [§38.2-3407.13. Refusal to accept assignments prohibited.

562 A. No insurer proposing to issue individual or group accident and sickness insurance policies
563 providing hospital, medical and surgical or major medical coverage on an expense incurred basis, no
564 corporation providing individual or group accident and sickness subscription contracts, no health
565 maintenance organization providing a health care plan for health care services, and no dental services
566 plan offering or administering prepaid dental services shall refuse to accept or make reimbursement
567 pursuant to an assignment of benefits made to a health care provider or hospital by an insured,
568 subscriber or plan enrollee, provided that if the health care provider or hospital obtains such
569 assignment of benefits, then the health care provider or hospital shall accept the reimbursement under
570 such assignment as payment in full for the services covered by such assignment and shall not charge or
571 bill the insured, subscriber or plan enrollee any further amount except for the amount of any applicable
572 deductible, copayment or coinsurance.

573 B. For the purpose of this section "assignment of benefits" means the transfer of health care
574 coverage reimbursement benefits or other rights under an insurance policy, subscription contract or
575 health care plan by an insured, subscriber or plan enrollee to a health care provider or hospital.

576 C. This section shall not apply to an assignment of benefits made to a dentist or oral surgeon.]

577 [§ 38.2-3418.8. Coverage for clinical trials for life-threatening diseases.

578 A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or
579 group accident and sickness insurance policies providing hospital, medical and surgical, or major
580 medical coverage on an expense-incurred basis; each corporation providing individual or group
581 accident and sickness subscription contracts; and each health maintenance organization providing a
582 health care plan for health care services shall provide coverage for clinical trials for life-threatening
583 diseases under any such policy, contract or plan delivered, issued for delivery, or renewed in this
584 Commonwealth on and after July 1, 1999.

585 B. The reimbursement for the participation in clinical trials for life-threatening diseases shall be
586 determined according to the same formula by which charges are developed for other medical and
587 surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and
588 coinsurance factors that are no less favorable than for physical illness generally.

589 C. For purposes of this section:

590 "Cooperative group" means a formal network of facilities that collaborate on research projects and
591 have an established NIH-approved peer review program operating within the group. "Cooperative
592 group" includes (i) the National Cancer Institute Clinical Cooperative group, (ii) the National Cancer
593 Institute Community Clinical Oncology Program, (iii) the AIDS Clinical Trials Group, and (iv) the
594 Community Programs for Clinical Research in AIDS.

595 "FDA" means the Federal Food and Drug Administration.

596 "Member" means a policyholder, subscriber, insured, or certificate holder or a covered dependent of
597 a policyholder, subscriber, insured or certificate holder.

598 "Multiple project assurance contract" means a contract between an institution and the federal
599 Department of Health and Human Services that defines the relationship of the institution to the federal
600 Department of Health and Human Services and sets out the responsibilities of the institution and the
601 procedures that will be used by the institution to protect human subjects.

602 "NIH" means the National Institutes of Health.

603 "Patient cost" means the cost of a medically necessary health care service that is incurred as a
604 result of the treatment being provided to the member for purposes of a clinical trial. "Patient cost" does
605 not include (i) the cost of nonhealth care services that a patient may be required to receive as a result
606 of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the
607 research associated with the clinical trial, or (iii) costs that would not be covered under the patient's
608 policy, plan, or contract for noninvestigational treatments.

609 D. Coverage for clinical trials for life-threatening diseases shall be provided for participation in a
610 clinical trial as a result of (i) a life-threatening condition or (ii) prevention, early detection, and
611 treatment studies on cancer. Such coverage shall be required if:

612 1. The treatment is being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for
613 cancer; or

2. The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial for any life-threatening condition other than cancer.

E. The treatment described in subsection D shall be provided by a clinical trial approved by:

1. One of the National Institutes of Health;

2. An NIH cooperative group or an NIH center;

3. The FDA in the form of an investigational new drug application;

4. The Federal Department of Veterans Affairs; or

5. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH.

F. The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

G. Coverage under this section shall apply only if:

1. There is no clearly superior, noninvestigational treatment alternative; and

2. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

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

§ 38.2-4209. Preferred provider subscription contracts.

A. As used in this section, a "preferred provider subscription contract" is a contract that specifies how services are to be covered when rendered by providers participating in a plan, by nonparticipating providers, and by preferred providers.

B. Notwithstanding the provisions of §§ 38.2-4218 and 38.2-4221, any nonstock corporation may, as a feature of its plan, offer preferred provider subscription contracts pursuant to the requirements of this section that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or other type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded. Differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or price differences among providers in different geographical areas shall not be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

D. Mandated types of providers listed in § 38.2-4221 and types of providers whose services are required to be made available and which have been specifically contracted for by the holder of any subscription contract shall, to the extent required by § 38.2-4221, have the same opportunity as do doctors of medicine to qualify for payment as preferred providers.

E. Preferred provider subscription contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

F. No contract between a nonstock corporation and a provider shall include provisions which include an incentive or specific payments made directly, in any form, to a health care provider or health care provider group as an inducement to deny services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions. This subsection does not prohibit the use of capitation as a method of payment, nor shall it prohibit the inclusion of provisions that include incentives or payments that reward providers or provider groups for providing services in a cost-effective manner or that promote the quality initiatives established under a managed care health insurance plan.

§ 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, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 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, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.9:01,

38.2-3407.10, 38.2-3407.11, 38.2-3407.11:1, 38.2-3407.12, [38.2-3407.13,] 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3501, 38.2-3502, 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, 38.2-3542, 38.2-3543.2, 38.2-3600 through 38.2-3607, Chapter 53 (§ 38.2-5300 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4306.1. Interest on claim proceeds.

A. If an action to recover the claim proceeds due under a health care plan results in a judgment against a health maintenance organization, interest on the judgment at the legal rate of interest shall be paid from the date of presentation to the health maintenance organization of proof of loss to the date judgment is entered.

B. If no action is brought, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the health maintenance organization's receipt of proof of loss to the date of claim payment.

C. This section shall not apply to individual contracts issued prior to July 1, 1990, but shall apply to any renewals or reissues of group contracts occurring after that date.

DC. This section shall not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the health maintenance organization's obligation on such claims.

ED. For purposes of this section, "proof of loss" means all necessary documentation reasonably required by the health maintenance organization to make a determination of benefit coverage.

§ 38.2-4312. Prohibited practices.

A. No health maintenance organization or its representative may cause or knowingly permit the use of (i) advertising that is untrue or misleading, (ii) solicitation that is untrue or misleading, or (iii) any form of evidence of coverage that is deceptive. For the purposes of this chapter:

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee or person considering enrollment in a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if the statement or item of information may be understood by a reasonable person who has no special knowledge of health care coverage as indicating (i) a benefit or advantage if that benefit or advantage does not in fact exist or (ii) the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee or person considering enrollment in a health care plan if the absence of that exclusion, limitation, or disadvantage does not in fact exist; consideration shall be given to the total context in which the statement is made or the item of information is communicated; and

3. An evidence of coverage shall be deemed to be deceptive if it causes a reasonable person who has no special knowledge of health care plans to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage; consideration shall be given to the evidence of coverage taken as a whole and to the typography, format, and language.

B. The provisions of Chapter 5 (§38.2-500 et seq.) of this title shall apply to health maintenance organizations, health care plans, and evidences of coverage except to the extent that the Commission determines that the nature of health maintenance organizations, health care plans, and evidences of coverage render any of the provisions clearly inappropriate.

C. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature (i) any of the words "insurance," "casualty," "surety," "mutual," or (ii) any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or fidelity and surety insurer doing business in this Commonwealth.

D. No health maintenance organization shall discriminate on the basis of race, creed, color, sex or religion in the selection of health care providers for participation in the organization.

E. No health maintenance organization shall unreasonably discriminate against physicians as a class or any class of providers listed in § 38.2-4221 or pharmacists when contracting for specialty or referral practitioners or providers, provided the plan covers services which the members of such classes are licensed to render. Nothing contained in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the numbers of providers necessary to render the services offered by the health maintenance organization.

F. No contract between a health maintenance organization and a provider shall include provisions which include an incentive or specific payments made directly, in any form, to a health care provider or health care provider group as an inducement to deny services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of

enrollees with similar medical conditions. This subsection does not prohibit the use of capitation as a method of payment, nor shall it prohibit the inclusion of provisions that include incentives or payments that reward providers or provider groups for providing services in a cost-effective manner or that promote the quality initiatives established under a managed care health insurance 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, 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 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 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 through 38.2-1309, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.1:1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.9:01, 38.2-3407.10, 38.2-3407.11, 38.2-3407.1:1, 38.2-3407.12, [38.2-3407.13,] 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.7, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 58 (§ 38.2-5800 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.

[§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 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, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.10, 38.2-3407.13, 38.2-3415, 38.2-3541, 38.2-3600 through 38.2-3603, and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

C. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not apply to either an optometric or dental services plan.]

§ 38.2-5804. Complaint system.

A. A health carrier subject to subsection B of § 38.2-5801 shall establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints in accordance with requirements in or established pursuant to provisions in this title and Title 32.1 and shall include the following:

1. A record of the complaints shall be maintained for no less than five years.

2. Such health carrier shall provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone number of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and electronic mail address of the Managed Care Ombudsman, and shall also specify any required limits imposed by or on behalf of the MCHIP. Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions pursuant to § 32.1-137.15.

B. The Commission, in cooperation with the State Health Commissioner, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this chapter shall be assessed by the State Health Commissioner pursuant to provisions in Title 32.1 and the regulations promulgated thereunder. Compliance by the

health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of this title, shall be assessed by the Commission.

C. The health carrier for each MCHIP shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission and the Board of Health. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the grievance or complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the MCHIP's affiliated providers.

D. The provisions of Chapter 5 (§ 38.2-500 et seq.) of this title shall apply to the health carrier, its MCHIPs, and evidence of coverage and representations thereto, except to the extent that the Commission determines that the nature of the health carrier, its MCHIP, and evidences of coverage and representations thereto render any of the provisions clearly inappropriate.

CHAPTER 59.

INDEPENDENT EXTERNAL REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS.

§ 38.2-5900. Application of chapter; definitions.

This chapter shall apply to all utilization review entities established pursuant to Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1. The definitions in § 32.1-137.7 shall have the same meanings ascribed to them in § 32.1-137.7 when used in this chapter.

§ 38.2-5901. Review by the Bureau of Insurance.

A. A covered person or a treating health care provider, with the consent of the covered person, may in accordance with this section appeal to the Bureau of Insurance for review of any final adverse decision concerning a health service costing more than \$500, determined in accordance with regulations adopted by the Commission. The appeal shall be filed within thirty days of the final adverse decision, shall be in writing on forms prescribed by the Bureau of Insurance, shall include a general release executed by the covered person for all medical records pertinent to the appeal, and shall be accompanied by a fifty-dollar nonrefundable filing fee. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. The Commission may, for good cause shown, waive the filing fee upon a finding that payment of the filing fee will cause undue financial hardship for the covered person. The Bureau of Insurance shall provide a copy of the written appeal to the utilization review entity which made the final adverse decision.

B. The Bureau of Insurance or its designee shall conduct a preliminary review of the appeal to determine (i) whether the applicant is a covered person or a treating health care provider with the consent of the covered person, (ii) whether the benefit or service that is the subject of the application reasonably appears to be a covered service costing more than \$500, (iii) whether all complaint and appeal procedures available under Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 have been exhausted, and (iv) whether the application is otherwise complete and filed in compliance with this section. Such preliminary review shall be conducted within fifteen days of receipt of all information and documentation necessary to conduct a preliminary review. The Bureau of Insurance shall not accept for review any application which fails to meet the criteria set forth in this subsection. Within five working days of completion of the preliminary review, the Bureau of Insurance or its designee shall notify the applicant and the utilization review entity in writing whether the appeal has been accepted for review, and if not accepted, the reasons therefor.

C. The covered person, the treating health care provider, and the utilization review entity shall provide copies of the medical records relevant to the final adverse decision to the Bureau of Insurance within ten working days after the Bureau of Insurance has mailed written notice of its acceptance of the appeal. The confidentiality of such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth. The Bureau of Insurance or its designee may, if deemed necessary, request additional medical records from the covered person, any treating health care provider or the utilization review entity. Failure to comply with such request within twenty working days from the date of such request may result in dismissal of the appeal or reversal of the final adverse decision in the discretion of the Commissioner of Insurance.

§ 38.2-5902. Appeals; impartial health entity.

A. The Bureau of Insurance shall contract with one or more impartial health entities for the purpose of performing the review of final adverse decisions. The Commission shall adopt regulations to assure that the impartial health entity conducting the review has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final adverse decision to determine whether the decision is objective, clinically valid, compatible with established principles of health care, and appropriate in light of the contractual obligations of the utilization review entity. The impartial health entity shall review the written appeal; the response of the utilization review entity; any

affidavits which either the covered person, the treating health care provider, or the utilization review entity may file with the Bureau of Insurance; and such medical records as the impartial health entity shall deem appropriate. The impartial health entity shall issue its written recommendation affirming, modifying or reversing the final adverse decision within sixty days of the acceptance of the appeal by the Bureau of Insurance. The Commissioner of Insurance, based upon such recommendation, shall issue a written ruling affirming, modifying or reversing the final adverse decision. Such written ruling shall not be construed as a final finding, order or judgment of the Commission. The Commissioner's written ruling shall carry out the recommendations of the impartial health entity unless the impartial health entity exceeded its authority or acted arbitrarily or capriciously. The written ruling of the Commissioner shall bind the covered person and the utilization review entity to the extent to which each would have been obligated by a judgment entered in an action at law or in equity with respect to the final adverse decision.

B. The Bureau of Insurance shall contract with one or more impartial health entities such as medical peer review organizations, independent utilization review companies, or other health care entities which the Bureau of Insurance shall determine to possess the necessary credentials and otherwise to be qualified to perform such review. Prior to assigning an appeal to an impartial health entity, the Bureau of Insurance shall verify that the impartial health entity conducting the review of a final adverse decision has no relationship or association with (i) the utilization review entity, or any officer, director or manager of such utilization review entity, (ii) the covered person, (iii) the treating health care provider, or any of its employees or affiliates, (iv) the medical care facility at which the covered service would be provided, or any of its employees or affiliates, or (v) the development or manufacture of the drug, device, procedure or other therapy which is the subject of the final adverse decision.

C. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of their powers and duties.

D. Any managed care health insurance plan licensee that is required to provide previously denied services as a result of the review by the impartial health entity shall be subject to payment of such fees as the Commission shall deem appropriate to cover the costs of the review.

§ 38.2-5903. Assessment to fund appeals.

A. Each licensed insurer, health maintenance organization, and health services plan doing business in the Commonwealth by writing any type of insurance as defined in § 38.2-109 shall pay, in addition to any other assessments provided in this title, an assessment in an amount not to exceed 0.015 percent of the direct gross premium income during the preceding calendar year. Such assessment shall be based upon the anticipated costs attributable to implementation of the review of final adverse decisions by the Bureau of Insurance pursuant to this chapter, adjusted for actual receipts and expenditures in the prior fiscal year. The assessment shall be apportioned and assessed and paid as prescribed by § 38.2-403.

B. The assessment shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

§ 38.2-5904. Managed Care Ombudsman established; responsibilities.

A. The Office of Managed Care Ombudsman is hereby created within the Bureau of Insurance. The Managed Care Ombudsman shall promote and protect the interests of covered persons under managed health insurance plans in the Commonwealth. All state agencies shall assist and cooperate with the Managed Care Ombudsman in the performance of his duties under this chapter. The definitions in § 32.1-137.7 shall have the same meanings ascribed to them in § 32.1-137.7 when used in this section.

B. The Managed Care Ombudsman shall:

1. Assist covered persons in understanding their rights and the processes available to them according to their managed health insurance plan.

2. Answer inquiries from covered persons and other citizens by telephone and electronic mail.

3. Provide to covered persons and other citizens information concerning managed care health insurance plans and other utilization review entities upon request.

4. Develop information on the types of managed health insurance plans available in the Commonwealth, including mandated benefits and utilization review procedures and appeals.

5. Make available, either separately or through an existing Internet web site utilized by the Bureau of Insurance, information as set forth in subdivision 4 and such additional information as he deems appropriate.

6. In conjunction with complaint and inquiry data collected and in accordance with § 38.2-5804, maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

7. Upon request, assist covered persons in using the procedures and processes available to them

921 *from their managed health insurance plan, including all utilization review appeals. Such assistance may*
922 *require the review of insurance and health care records of a covered person, which shall be done only*
923 *with that person's express written consent. The confidentiality of any such medical records shall be*
924 *maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.*

925 *8. Ensure that covered persons have access to the services provided through the Office and that the*
926 *covered persons receive timely responses from the representatives of the Office to the inquiries.*

927 *9. Provide assessments of proposed and existing managed care health insurance laws and other*
928 *studies of managed care health insurance plan issues upon request by any of the standing committees of*
929 *the General Assembly having jurisdiction over insurance or health or the Joint Commission on Health*
930 *Care.*

931 *10. Monitor changes in federal and state laws relating to health insurance.*

932 *11. Report annually on his activities to the standing committees of the General Assembly having*
933 *jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of*
934 *each year, which report shall include a summary of significant new developments in federal and state*
935 *laws relating to health insurance each year.*

936 *12. Carry out activities as the Commission determines to be appropriate.*

937 *§ 38.2-5905. Rules and regulations.*

938 *The Commission shall promulgate regulations effectuating the purpose or this chapter. Such*
939 *regulations shall include (i) provisions for expedited consideration of appeals in cases involving*
940 *emergency health care and (ii) standards, credentials and qualifications for impartial health entities.*

941 **2. That the State Corporation Commission shall promulgate the first set of regulations to**
942 **implement the provisions of Chapter 59 of Title 38.2 of this act to be effective within 280 days of**
943 **the enactment of this provision.**

944 **3. This act shall take effect on July 1, 1999; however, the appeal processes set forth in Chapter 59**
945 **of Title 38.2 of this act shall not take effect until the earlier of (i) ninety days following the**
946 **promulgation of regulations by the State Corporation Commission as set forth in § 38.2-5905 or**
947 **(ii) July 1, 2000. The provisions of this act amending §§ 38.2-3407.1 and 38.2-4306.1 and adding**
948 **38.2-3407.1:1 shall not become effective until July 1, 2000.**

949 **[4. The provisions of Section 38.2-3407.13 and Section 38.2-3418.8 shall become effective only if**
950 **reenacted by the 2000 General Assembly. Prior to the 2000 General Assembly the Joint**
951 **Commission on Health Care in consult with the Bureau of Insurance shall review the financial**
952 **impact that the enactment of these sections would have on health care costs, health insurance**
953 **premiums and the availability of health care and health insurance.]**