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HOUSE BILL NO. 726

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Corporations, Insurance and Banking on February 3, 2000)

(Patron Prior to Substitute—Delegate Rust)

A BILL to amend and reenact §§ 32.1-137.6, 32.1-137.15, 38.2-3407.10, 38.2-3407.11:1, 38.2-3418.9, 38.2- 4214, 38.2-4319, 38.2-4509, 38.2-5803, 38.2-5804, 38.2-5900, 38.2-5901, 38.2-5902, and 38.2-5904 of the Code of Virginia, relating to managed care health insurance plans generally.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.6, 32.1-137.15, 38.2-3407.10, 38.2-3407.11:1, 38.2-3418.9, 38.2- 4214, 38.2-4319, 38.2-4509, 38.2-5803, 38.2-5804, 38.2-5900, 38.2-5901, 38.2-5902, and 38.2-5904 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-137.6. Complaint system.

A. Each managed care health insurance plan licensee subject to § 32.1-137.2 shall establish and maintain for each of its managed care health insurance plans a complaint system approved by the Commissioner and the Bureau of Insurance to provide reasonable procedures for the resolution of written complaints in accordance with the requirements established under this article and Title 38.2, and shall include the following:

1. A record of the complaints shall be maintained for the period set forth in § 32.1-137.16 for review by the Commissioner.

2. Each managed care health insurance plan licensee 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 the electronic mail address of the *Office of the* Managed Care Ombudsman established pursuant to § 38.2-5904 and shall also specify any required limits imposed by or on behalf of the managed care health insurance plan. 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 Commissioner, in cooperation with the Bureau of Insurance, 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 article shall be assessed by the State Health Commissioner under this article. 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 Title 38.2, shall be assessed by the Bureau of Insurance.

C. As part of the renewal of a certificate, each managed care health insurance plan licensee shall submit to the Commissioner and to the *Office of the* Managed Care Ombudsman an annual complaint report in a form agreed and prescribed by the Board and the Bureau of Insurance. The complaint report shall include, but shall not be limited to (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the 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 managed care health insurance plan's health care providers.

The Department of Personnel and Training and the Department of Medical Assistance Services shall file similar periodic reports with the Commissioner, in a form prescribed by the Board, providing appropriate information on all complaints received concerning quality of care and utilization review under their respective health benefits program and managed care health insurance plan licensee contractors.

D. The Commissioner shall examine the complaint system under subsection B for compliance of the complaint system with respect to quality of care and shall require corrections or modifications as deemed necessary.

E. The Commissioner shall have no jurisdiction to adjudicate individual controversies arising under this article.

F. The Commissioner of Health or the nonprofit organization pursuant to § 32.1-276.4 may prepare a summary of the information submitted pursuant to this provision and § 32.1-122.10:01 to be included in the patient level data base.

§ 32.1-137.15. Final adverse decision; appeal.

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 *Office of the* Managed Care Ombudsman. Further, such notification shall advise any such covered person that, except in the instance of fraud, any such appeal herein may preclude such person's exercise of any other right or remedy relating to such adverse decision. An expedited appeals process of no more than twenty-four hours shall be established and conducted by telephone to consider any final adverse decision that relates to a prescription to alleviate cancer pain.

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 treating health care provider shall have the opportunity to appeal immediately, by telephone, on an expedited basis, an adverse decision or adverse reconsideration relating to a prescription to alleviate cancer pain.

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 or would subject the cancer patient to pain. 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 Article 2.1 (§ 32.1-138.6 et seq.) of Chapter 5 of this title, 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.

§ 38.2-3407.10. 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.

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

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

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

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

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

1. Notifying an enrollee of:

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee 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 enrollee's option, continue for the remainder of the enrollee's life for care directly related to the treatment of the

terminal illness.

4. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

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

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

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

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

J. No contract between a carrier and a provider shall prohibit, impede or interfere in the discussion 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~~*for* medical treatment shall have personnel available to provide such ~~authorization~~*preauthorization* 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. *Such notice shall be provided to the group policyholder as a separate and distinct notification, and may not be combined with any other notification or marketing materials.*

N. No contract between a provider and a carrier shall include provisions which require a health care provider or health care provider group to deny covered 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.

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

P. 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. However, the ninety-day period referred to in subdivisions C 1 b and C 2 of this section, the requirements set forth in subdivisions F 2 and F 3, 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~~*a standing referral*, 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, after consultation with the primary care physician, 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.~~ *If the care of a covered individual who has an ongoing special condition would, as determined by the primary care physician, most appropriately be coordinated by a specialist for such condition, each insurer, corporation, or health maintenance organization, in connection with the provision of health insurance coverage, shall have a procedure by which such individual shall, after consultation with the primary care physician, receive a referral to a specialist for such condition. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual for the special condition without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the special condition as the individual's primary care provider would otherwise be permitted to provide or authorize.* 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 related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize.~~

~~D~~*C.* 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~~*a participating* 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 *participating* specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist.

~~E~~*D.* 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~~*E.* Each insurer, corporation or health maintenance organization subject to the provisions of this section shall inform subscribers of the provisions of this section. Such notice shall be provided in writing, and included in the policy or evidence of coverage.

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

§ 38.2-3418.9. Minimum hospital stay for hysterectomy.

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

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

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

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

§ 38.2-4214. 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 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 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.) ~~and Chapter 59 (§ 38.2-5900 et seq.) of this title,~~ *and § 38.2-5903 of this title* shall apply to the operation of a plan.

§ 38.2-4319. (Effective until July 1, 2004) 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.), §§ 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, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.11, 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.)~~and Chapter 59 (§ 38.2-5900 et seq.) of this title,~~ *and § 38.2-5903 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.

§ 38.2-4319. (Effective July 1, 2004) 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.), §§ 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, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.11, 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.) ~~and Chapter 59 (§ 38.2-5900 et seq.) of this title,~~ *and § 38.2-5903 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, 38.2-3407.14, 38.2-3407.15, 38.2-3415, 38.2-3541, 38.2-3600 through 38.2-3603, Chapter 58 (§ 38.2-5800 et seq.) ~~and Chapter 59 (§ 38.2-5900 et seq.) of this title,~~ *and § 38.2-5903 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.

§ 38.2-5803. Disclosures and representations to enrollees.

A. The following shall be provided to the MCHIP's covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and shall be made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.

2. A description of the service area or areas within which the MCHIP shall provide health care services.

3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.

4. Notice that the MCHIP is subject to regulation in this Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice included within the evidence of coverage, providing substantially the following: "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance." Such notice shall also provide the toll-free telephone number, mailing address, and electronic mail address of the Office of the Managed Care Ombudsman.

B. The following shall apply to MCHIPs that require a covered person to select a primary care physician with respect to the offer of basic health care services by the MCHIP:

1. At the time of enrollment each covered person shall have the right to select a primary care physician from among the health carrier's affiliated primary care physicians for the MCHIP, subject to availability.

2. Any covered person who is dissatisfied with his primary care physician shall have the right to select another primary care physician from among the affiliated primary care physicians, subject to availability. The health carrier may impose a reasonable waiting period for this transfer.

§ 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 *Office 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~~*Office of the Managed Care Ombudsman* 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.

§ 38.2-5900. 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~~ *As* used in this chapter~~.~~*:*

"Covered person" means an individual, whether a policyholder, subscriber, enrollee, covered dependent, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan as defined in and subject to regulation under Chapter 58, when such coverage is provided under a contract issued in this Commonwealth.

"Final adverse decision" means a utilization review determination denying benefits or coverage, and concerning which all internal appeals available to the covered person pursuant to Title 32.1 have been exhausted.

"Treating health care provider" means a licensed health care provider who renders or proposes to render health care services to a covered person.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person. For purposes of this chapter, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered. "Utilization review" shall also include determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures, by whatever terms designated in the evidence of coverage. "Utilization review" shall not include (i) any denial of benefits or services for a procedure which is explicitly excluded pursuant to the terms of the contract or evidence of coverage, (ii) any review of issues concerning contractual restrictions on facilities to be used for the provision of services, or (iii) any determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract in insurance covering any classes of insurance defined in §§ 38.2-117, 38.2-118, 38.2-119, 38.2-124, 38.2-125, 38.2-126, 38.2-130, 38.2-131, 38.2-132, and 38.2-134.

"Utilization review entity" means an insurer or managed care health insurance plan licensee that performs utilization review or upon whose behalf utilization review is performed with regard to the health care or proposed health care that is the subject of the final adverse decision.

§ 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 *appeal to the Bureau of Insurance for review of any final adverse decision* in accordance with ~~this section appeal to the Bureau of Insurance for review of any final adverse decision~~ *regulations promulgated by the Commission* concerning a health service ~~costing more than $500~~ *for which the actual cost to the covered person would exceed $300 if the final adverse decision is not reversed,* 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~~*Bureau of Insurance* 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~~*Bureau of Insurance* 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 *acting* 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~~ *for which the actual cost to the covered person would exceed $300 if the final adverse decision is not reversed,* (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 ~~five~~*ten* working 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 ~~three~~*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~~*twenty* working days after the Bureau of Insurance has mailed written notice of its acceptance

of the appeal. *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.* 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 ~~ten~~*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.

D. The Commissioner of Insurance, upon good cause shown, may provide an extension of time for the covered person, the treating health care provider, the utilization review entity and the ~~Commission~~*Bureau of Insurance* to meet the established time requirements set forth in this section.

§ 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 under the terms of the contractual obligations to the covered person. 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 thirty working days of the ~~acceptance of the appeal by the Bureau of Insurance~~*date that the impartial review entity has received from all parties all documentation and information necessary for it to complete its review*. The Commissioner of Insurance, based upon such recommendation, shall issue a written ruling affirming, modifying or reversing the final adverse decision *within ten working days after his receipt of the recommendation of the impartial review entity*. Such written ruling shall not be construed as a final finding, order or judgment of the Commission, and shall be exempt from the application of the Administrative Process Act (§ 9-6.14:1 et seq.). The Commissioner's written ruling shall ~~carry out~~*affirm* the recommendations of the impartial health entity unless *the Commissioner finds in his ruling that* 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 ~~issuer of the covered person's policy or contract for health benefits~~ *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 issues which the impartial review entity may examine when reviewing a final adverse decision under this section. *Failure by the utilization review entity to comply with the Commissioner's written ruling within thirty days of the date of such ruling shall be deemed a knowing and willful violation of this section.* The impartial health entity shall not be affiliated or a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

B. The Bureau of Insurance shall contract with one or more impartial health entities such as medical peer review organizations and independent utilization review companies *which the Bureau of Insurance shall determine to possess the necessary credentials and otherwise 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. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

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 his powers and duties.

D. Any ~~managed care health insurance plan licensee~~ *utilization review entity* 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~~*Commissioner of Insurance, in his sole discretion,* shall deem appropriate to cover the costs of the review. *All such fees shall be collected by the Bureau of Insurance 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. Failure by the utilization review entity*

to remit such fee within thirty days of the date notice of such fee is mailed to the utilization review entity shall be deemed a knowing and willful violation of this section.

§ 38.2-5904. Office of the Managed Care Ombudsman established; responsibilities.

A. The ~~Office of the Managed Care Ombudsman is hereby created~~ *Commission shall create* within the Bureau of Insurance *the Office of the Managed Care Ombudsman*. The *Office of the* Managed Care Ombudsman shall promote and protect the interests of covered persons under managed *care* health insurance plans in the Commonwealth. All state agencies shall assist and cooperate with the *Office of the* Managed Care Ombudsman in the performance of ~~his~~*its* 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 *Office of the* Managed Care Ombudsman shall:

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

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

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 *care* health insurance plans available in the Commonwealth, including mandated benefits and utilization review procedures and appeals, *and receive and analyze the annual complaint data required to be filed by each health carrier providing a managed care health insurance plan, as provided in subsection C of § 38.2-5804*.

5. Make available, either separately or through an existing Internet website utilized by the Bureau of Insurance, information as set forth in subdivision 4 and such additional information as ~~he deems~~*may be deemed* appropriate.

6. In conjunction with complaint and inquiry data maintained by the Bureau of Insurance, 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 from their managed *care* health insurance plan, including all utilization review appeals. Such assistance may require the review of insurance and health care records of a covered person, which shall be done only with that person's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

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

9. ~~Provide assessments of proposed and existing managed care health insurance laws and other studies of managed care health insurance plan issues upon~~ *Upon* request *to the Commission* by any of the standing committees of the General Assembly having jurisdiction over insurance or health or the Joint Commission on Health Care, *provide to the Commission for dissemination to the requesting parties assessments of proposed and existing managed care health insurance laws and other studies of managed care health insurance plan issues*.

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

11. ~~Report annually on his activities~~ *Provide information to the Commission that will permit the Commission to report annually on the activities of the Office of the Managed Care Ombudsman* to the standing committees of the General Assembly having jurisdiction over insurance and over health and *to* the Joint Commission on Health Care. *The Commission's report shall be filed* by December 1 of each year, ~~which report~~*and* shall include a summary of significant new developments in federal and state laws relating to health insurance each year.

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