003304254

SENATE BILL NO. 73

Offered January 12, 2000

A BILL to amend and reenact §§ 38.2-4300, 38.2-4301, 38.2-4302, 38.2-4307.1, 38.2-4310, 38.2-4317.1, and 38.2-4319, as it is in effect and as it will become effective, of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-4310.1, relating to health maintenance organizations.

Patron—Colgan

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4300, 38.2-4301, 38.2-4302, 38.2-4307.1, 38.2-4310, 38.2-4317.1, and 38.2-4319, as it is in effect and as it will become effective, of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-4310.1, as follows:

§ 38.2-4300. Definitions.

As used in this chapter:

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

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

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

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

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

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

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

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, including emergency services and services rendered by nonparticipating referral providers, as distinguished from mere

indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a significant part shall mean at least ninety percent of total costs of health care services.

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

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

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

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

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

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

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

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

§ 38.2-4301. Establishment of health maintenance organizations.

A. No person shall establish or operate a health maintenance organization in this Commonwealth without obtaining a license from the Commission. Any person, including a foreign corporation, may apply to the Commission for a license to establish and operate a health maintenance organization in compliance with this chapter.

B. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:

1. A copy of any basic organizational document of the applicant including, but not limited to, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents;

2. A copy of the bylaws, rules and regulations, or any similar document regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, and official positions, *and biographical information on forms acceptable to the Commission* of each member of the governing body~~,~~ *and any person with authority to manage or establish policy;* and a full disclosure in the application of (i) any financial interest between ~~any officer or member of the governing body~~ *such persons* or any provider, organization or corporation owned or controlled by such person and the health maintenance organization, and (ii) the extent and nature of the financial arrangements between such persons and the health maintenance organization;

4. A copy of any contract made or to be made between any providers, sponsors or organizers of the health maintenance organization, or persons listed in subdivision 3 of this subsection and the applicant;

5. A copy of the evidence of coverage form to be issued to subscribers;

6. A copy of any group contract form that is to be issued to employers, unions, trustees, or other organizations. All group contracts shall set forth the right of subscribers to convert their coverages to an individual contract issued by the health maintenance organization;

7. Financial statements showing the applicant's assets, liabilities, and sources of financial support ~~or~~ *and,* if the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent ~~regular~~ certified financial statement unless the Commission directs that additional or more recent financial information is required for the proper administration of this chapter;

8. A complete description of the health maintenance organization and its method of operation, including (i) the method of marketing the plan, (ii) ~~a financial plan that includes a three-year projection~~

~~of~~ ~~the~~ ~~anticipated~~ ~~initial~~ ~~operating~~ ~~results,~~ ~~(iii)~~ a statement regarding the sources of working capital as well as any other sources of funding, and ~~(iv)~~ *(iii)* a description of any insurance, reinsurance or alternative coverage arrangements proposed*, including excess insurance or stop loss insurance*;

9. A description of the mechanism by which enrollees will be given an opportunity to participate in matters of policy and operation as provided in subsection B of § 38.2-4304; ~~and~~

10. *A financial feasibility plan which includes, but is not limited to, (i) detailed enrollment projections, (ii) the methodology for determining premium rates to be charged during at least the first three years of operations and extending one year beyond the anticipated break-even point certified by an actuary, and (iii) a projection, along with material assumptions, of balance sheets, cash flow statements showing capital expenditures and purchase and sale of investments, income statements, and statements of anticipated covered and uncovered expenses on a quarterly basis for at least three years and extending one year beyond the anticipated break-even point; and*

11. Any other information the Commission may require to make the determinations required pursuant to § 38.2-4302.

§ 38.2-4302. Issuance of license; fee; minimum net worth; impairment.

A. The Commission shall issue a license to a health maintenance organization after the receipt of a complete application and payment of a $500 nonrefundable application fee if the Commission is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and reputable;

2. The health care plan constitutes an appropriate mechanism for the health maintenance organization to provide or arrange for the provision of, as a minimum, basic health care services or limited health care services on a prepaid basis, except to the extent of reasonable requirements for copayments;

3. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commission may consider:

a. The financial soundness of the health care plan's arrangements for health care services and the schedule of prepaid charges used for those services;

b. The adequacy of working capital;

c. Any agreement with an insurer, a health services plan, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage if the health care plan is discontinued;

d. Any contracts with health care providers that set forth the health care services to be performed and the providers' responsibilities for fulfilling the health maintenance organization's obligations to its enrollees;

e. The deposit of ~~a~~ ~~surety~~ ~~bond~~ ~~or~~ ~~deposit~~ ~~of~~ *acceptable* securities in an amount satisfactory to the Commission, submitted in accordance with § 38.2-4310 as a guarantee that the obligations to the enrollees will be duly performed; ~~and~~

f. The applicant's net worth which shall include minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than $600,000, up to a maximum of $4 million; uncovered expenses shall be amounts determined ~~for~~ *from* the most recently ended calendar quarter pursuant to regulations promulgated by the Commission*; and*

g. A financial statement of the health maintenance organization on the form required by § 38.2-4307.

4. The enrollees will be given an opportunity to participate in matters of policy and operation as required by § 38.2-4304; and

5. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-4301 or Chapter 58 (§ 38.2-5800 et seq.) or by independent investigation. *Issuance of a license shall not constitute approval of the forms submitted under subdivisions 5, 6, and 11 of subsection B of § 38.2- 4301.*

B. A licensed health maintenance organization shall have and maintain at all times the minimum net worth described in subdivision 3 f of subsection A of this section.

1. If the Commission finds that the minimum net worth of a domestic health maintenance organization is impaired, the Commission shall issue an order requiring the health maintenance organization to eliminate the impairment within a period not exceeding ninety days. The Commission may by order served upon the health maintenance organization prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If at the expiration of the designated period the health maintenance organization has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the health maintenance organization may be entered as provided in § 38.2-4317.

2. If the Commission finds an impairment of the minimum net worth of any foreign health maintenance organization, the Commission may order the health maintenance organization to eliminate

the impairment and restore the minimum net worth to the amount required by this section. The Commission may, by order served upon the health maintenance organization, prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If the health maintenance organization fails to comply with the Commission's order within a period of not more than ninety days, the Commission may, in the manner set out in § 38.2-4316, suspend or revoke the license of the health maintenance organization.

3. Prior to December 31, 1999, a health maintenance organization with less than minimum net worth which is licensed on and after June 30, 1998, may continue to operate as a licensed health maintenance organization without a finding of impairment if the licensee has net worth (i) on June 30, 1998, and up to December 31, 1998, in an amount at least equal to the sum of uncovered expenses, but not less than $300,000, up to a maximum of $2 million; (ii) on December 31, 1998, and up to June 30, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $400,000, up to a maximum of $2.5 million; and (iii) on June 30, 1999, and up to December 31, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $500,000, up to a maximum of $3 million.

§ 38.2-4307.1. Additional reports.

A. In addition to the annual statement, the Commission may require a licensed health maintenance organization to file additional reports, exhibits or statements considered necessary to secure complete information concerning the condition, solvency, experience, transactions or affairs of the health maintenance organization. The Commission shall establish reasonable deadlines for filing these additional reports, exhibits, or statements and may require verification by any officers of the health maintenance organization designated by the Commission.

B. The Commission may require a licensed health maintenance organization to file with the National Association of Insurance Commissioners (NAIC) a copy of its financial statement required to be filed pursuant to § 38.2-4307, on a quarterly basis. Unless otherwise prescribed by the Commission, all such financial statements, whether filed with the Commission or the NAIC, shall be prepared in accordance with applicable provisions of the annual statement instructions and the accounting practices and procedures manual adopted by the NAIC, or any successor publications. The Commission may prescribe that additional copies of financial statements and other ~~publications~~ *reports* be filed in machine-readable format.

C. Each annual and quarterly statement shall be accompanied by a statement of covered and uncovered expenses. The statement shall be prepared in accordance with instructions prescribed by the Commission for reporting the expenses of the health maintenance organization during the three months comprising the most recently ended calendar-year quarter.

§ 38.2-4310. Protection against insolvency.

A. Each health maintenance organization shall deposit *and maintain* acceptable securities with the State Treasurer in ~~an amount satisfactory to the Commission to~~ *amounts prescribed by § 38.2-4310.1. The deposit shall* be held as a special fund in trust, as a guarantee that the obligations to the enrollees who are residents of this Commonwealth will be performed. The securities shall be deposited pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership interests effected on the records of a depository and its participants pursuant to rules and procedures established by the depository. ~~The Commission may waive this requirement whenever the Commission is satisfied that the assets of the organization or its contract with insurers, health services plans, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.~~ *Upon a determination of insolvency or action by the Commission pursuant to § 38.2-4317, the deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of covered services to enrollees. If a health maintenance organization is placed in receivership, the deposit shall be an asset subject to the provisions of Chapter 15 of this title.*

B. The Commission may require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. ~~The plan may also provide for payment of outstanding obligations to enrollees and providers.~~ In considering such a plan, the Commission may require:

1. Insurance satisfactory in form and content to the Commission to cover the expenses to be paid for continued benefits after an insolvency;

2. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

3. Acceptable letters of credit;

~~4. A special deposit to secure providers not party to contracts under § 38.2-4311 equal to the lesser of (i) one percent of premiums determined in accordance with Chapter 4 of this title or (ii) three months' health care expenses as determined by Commission regulation attributable to providers not party~~

~~to such contracts and incurred for care and treatment of enrollees who are residents of this Commonwealth;~~ or

~~5.~~ *4.* Any other arrangements to assure that benefits are continued as specified above.

C. 1. In the event of an insolvency of a health maintenance organization, all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon a date to be prescribed by the Commission. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates then in effect for its enrollees in such group.

2. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the Commission determines that the other health benefit plan lacks sufficient health care delivery resources to assure that health care services shall be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the Commission may allocate equitably the insolvent health maintenance organization's group contracts for such groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer such group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

3. The Commission may also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer such nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by his type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

D. 1. Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

2. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those employees and dependents validly covered under the prior carrier's contract or policy on the date of discontinuance.

~~E. Every health maintenance organization subject to the provisions of this section having physical securities deposited with the State Treasurer on or before June 30, 1992, shall deposit securities pursuant to a book-entry system as required by subsection A not later than January 1, 1993.~~

§ 38.2-4310.1. Deposits.

A. A health maintenance organization shall make its initial deposit prior to licensure in an amount not less than $300,000. The Commission shall review a health maintenance organization's deposit requirement at least once each year and may require an additional deposit in an amount equal to the greater of (i) the sum of all uncovered expenses for the most recent three months reported in accordance with § 38.2-4307.1 B or (ii) the value of liabilities representing uncovered health care expenses.

B. The Commission may reduce or waive, and also may direct the State Treasurer to return, any or all of a deposit requirement whenever the Commission, in its discretion, is satisfied that the assets of the health maintenance organization or its contracts with insurers, health services plans, governments, or other organizations are sufficient to assure the performance of its obligations to enrollees.

C. A health maintenance organization that has experienced an operating profit for the two most recent years may request that its deposit requirement be reduced. "Operating profit" shall be determined

by reference to the annual statements filed by the health maintenance organization and shall mean the excess of total revenue, excluding net investment income, over total expenses.

§ 38.2-4317.1. Insolvency deposit assessment.

In the event of an insolvency of a health maintenance organization occurring after July 1, 1989, the Commission may, (i) in the absence of an assumption under subsection C of § 38.2-4317 that is satisfactory to the Commission and that occurred within sixty days after entry of an order of impairment or insolvency, and (ii) after notice and hearing, levy an assessment on premiums due by licensed health maintenance organizations on contracts issued or renewed in this Commonwealth after the date of such assessment; provided, that such assessments for all health maintenance organization insolvencies in any calendar year shall not exceed two percent of the premiums subject to such assessments. Such assessments shall be paid quarterly to the Commission, and upon receipt by the Commission shall be paid over into the deposit account of the insolvent health maintenance organization held pursuant to subsection A of § 38.2-4310 for the benefit of enrollees for use and disbursement in accordance with *this section, § 38.2-4317, and applicable* Commission regulations. No participating provider, as defined in § 38.2-4300, may, either directly or indirectly, receive reimbursement from any such assessments. A receiver of such an insolvent health maintenance organization appointed pursuant to § 38.2-4317 may borrow in anticipation of collection of such assessments to meet obligations under a deposit account. Any assessments levied on account of a health maintenance organization insolvency in excess of obligations to enrollees shall be ratably returned to the health maintenance organizations paying such assessments.

§ 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, *38.2-216,* 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.), §§ *38.2-1017 through 38.2-1023,* 38.2-1057, ~~38.2-1306.2~~ *38.2-1306* 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.),~~ Chapter 58 (§ 38.2-5800 et seq.) and Chapter 59 (§ 38.2-5900 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.

E. For purposes of applying this section, "insurer" when used in a section cited in subsection A of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 38.2-4319. (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, *38.2-216,* 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.), §§ *38.2-1017 through 38.2-1023,* 38.2-1057, ~~38.2-1306.2~~ *38.2-1306* 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.),~~ Chapter 58 (§ 38.2-5800 et seq.) and Chapter 59 (§ 38.2-5900 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.

E. For purposes of applying this section, "insurer" when used in a section cited in subsection A of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.