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HOUSE BILL NO. 2768

Offered January 19, 2001

A BILL to amend and reenact §§ 2.1-20.1, 38.2-4214, 38.2-4319, as it is currently effective and as it will become effective, and 38.2-4509 of the Code of Virginia, to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.17, and to repeal § 38.2-3407.12 of the Code of Virginia, relating to managed care health insurance plans; state employee health insurance plan; freedom to choose.

Patrons—Cranwell, Amundson, Barlow, Diamonstein, Grayson, Hall, Thomas, Watts and Woodrum

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-20.1, 38.2-4214, 38.2-4319, as it is currently effective and as it will become effective, and 38.2-4509 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.17, 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 Human Resource Management 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 Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be

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59 provided incorporating any changes in such Guidelines or Standards within six months of the publication
60 of such Guidelines or Standards or any official amendment thereto.

61 4. a. Include an appeals process for resolution of written complaints concerning denials or partial
62 denials of claims that shall provide reasonable procedures for resolution of such written complaints and
63 shall be published and disseminated to all covered state employees. Such appeals process shall include a
64 separate expedited emergency appeals procedure which shall provide resolution within one business day
65 of receipt of a complaint concerning situations requiring immediate medical care. For appeals involving
66 adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial
67 health entities to review such decisions. Impartial health entities may include medical peer review
68 organizations and independent utilization review companies. The Department shall adopt regulations to
69 assure that the impartial health entity conducting the reviews has adequate standards, credentials and
70 experience for such review. The impartial health entity shall examine the final denial of claims to
71 determine whether the decision is objective, clinically valid, and compatible with established principles
72 of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of
73 fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if
74 consistent with law and policy.

75 b. Prior to assigning an appeal to an impartial health entity, the Department shall verify that the
76 impartial health entity conducting the review of a denial of claims has no relationship or association
77 with (i) the covered employee, (ii) the treating health care provider, or any of its employees or affiliates,
78 (iii) the medical care facility at which the covered service would be provided, or any of its employees or
79 affiliates, or (iv) the development or manufacture of the drug, device, procedure or other therapy which
80 is the subject of the final denial of a claim. The impartial health entity shall not be a subsidiary of, nor
81 owned or controlled by, a health plan, a trade association of health plans, or a professional association
82 of health care providers. There shall be no liability on the part of and no cause of action shall arise
83 against any officer or employee of an impartial health entity for any actions taken or not taken or
84 statements made by such officer or employee in good faith in the performance of his powers and duties.

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

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

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

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

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

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

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

120 11. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for

annual testing performed by any FDA-approved gynecologic cytology screening technologies.

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, 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, 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 related to the initial referral 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 physician's 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 clause a, 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 postpartum care directly related to the delivery.

e. Notwithstanding the provisions of clause a, 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.

f. A provider who continues to render health care services pursuant to this subdivision shall be reimbursed in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

16. a. Include coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

b. The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other

182 medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles,
183 copayments and coinsurance factors that are no less favorable than for physical illness generally.

184 c. For purposes of this subdivision:

185 "Cooperative group" means a formal network of facilities that collaborate on research projects and
186 have an established NIH-approved peer review program operating within the group. "Cooperative group"
187 includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer
188 Institute Community Clinical Oncology Program.

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

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

194 "NCI" means the National Cancer Institute.

195 "NIH" means the National Institutes of Health.

196 "Patient" means a person covered under the plan established pursuant to this section.

197 "Patient cost" means the cost of a medically necessary health care service that is incurred as a result
198 of the treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not
199 include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the
200 treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research
201 associated with the clinical trial, or (iii) the cost of the investigational drug or device.

202 d. Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be
203 provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such
204 treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a
205 Phase I clinical trial.

206 e. The treatment described in clause d shall be provided by a clinical trial approved by:

207 (1) The National Cancer Institute;

208 (2) An NCI cooperative group or an NCI center;

209 (3) The FDA in the form of an investigational new drug application;

210 (4) The federal Department of Veterans Affairs; or

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

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

215 g. Coverage under this section shall apply only if:

216 (1) There is no clearly superior, noninvestigational treatment alternative;

217 (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will
218 be at least as effective as the noninvestigational alternative; and

219 (3) The patient and the physician or health care provider who provides services to the patient under
220 the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to
221 procedures established by the plan.

222 17. Include coverage providing a minimum stay in the hospital of not less than twenty-three hours
223 for a covered employee following a laparoscopy-assisted vaginal hysterectomy and forty-eight hours for
224 a covered employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally
225 recognized guidelines. Nothing in this subdivision shall be construed as requiring the provision of the
226 total hours referenced when the attending physician, in consultation with the covered employee,
227 determines that a shorter hospital stay is appropriate.

228 18. (Effective until July 1, 2004) a. Include coverage for biologically based mental illness.

229 b. For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous
230 condition caused by a biological disorder of the brain that results in a clinically significant syndrome
231 that substantially limits the person's functioning; specifically, the following diagnoses are defined as
232 biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective
233 disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder,
234 attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

235 c. Coverage for biologically based mental illnesses shall neither be different nor separate from
236 coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit
237 year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment
238 limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment
239 and coinsurance factors.

240 d. Nothing shall preclude the undertaking of usual and customary procedures to determine the
241 appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this
242 option, provided that all such appropriateness and medical necessity determinations are made in the same
243 manner as those determinations made for the treatment of any other illness, condition or disorder

covered by such policy or contract.

e. In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

19. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

20. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

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 Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as an option, coverage for vision and dental care. 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 Human Resource Management 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

305 apply to any state agency authorized by the Department to establish and administer its own health
306 insurance coverage plan separate from the plan established by the Department.

307 H. 1. Any self-insured group health insurance plan established by the Department of Human
308 Resource Management that includes coverage for prescription drugs on an outpatient basis may apply a
309 formulary to the prescription drug benefits provided by the plan if the formulary is developed, reviewed
310 at least annually, and updated as necessary in consultation with and with the approval of a pharmacy
311 and therapeutics committee, a majority of whose members are actively practicing licensed (i)
312 pharmacists, (ii) physicians, and (iii) other health care providers.

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

319 I. Any plan established by the Department of Human Resource Management requiring
320 preauthorization prior to rendering medical treatment shall have personnel available to provide
321 authorization at all times when such preauthorization is required.

322 J. Any plan established by the Department of Human Resource Management shall provide to all
323 covered employees written notice of any benefit reductions during the contract period at least thirty days
324 before such reductions become effective.

325 K. No contract between a provider and any plan established by the Department of Human Resource
326 Management shall include provisions which require a health care provider or health care provider group
327 to deny covered services that such provider or group knows to be medically necessary and appropriate
328 that are provided with respect to a covered employee with similar medical conditions.

329 L. 1. The Department of Human Resource Management shall appoint an Ombudsman to promote and
330 protect the interests of covered employees under any state employee's health plan.

331 2. The Ombudsman shall:

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

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

335 c. Provide to covered employees information concerning the state health plans.

336 d. Develop information on the types of health plans available, including benefits and complaint
337 procedures and appeals.

338 e. Make available, either separately or through an existing Internet web site utilized by the
339 Department of Human Resource Management, information as set forth in clause d and such additional
340 information as he deems appropriate.

341 f. Maintain data on inquiries received, the types of assistance requested, any actions taken and the
342 disposition of each such matter.

343 g. Upon request, assist covered employees in using the procedures and processes available to them
344 from their health plan, including all appeal procedures. Such assistance may require the review of health
345 care records of a covered employee, which shall be done only with that employee's express written
346 consent. The confidentiality of any such medical records shall be maintained in accordance with the
347 confidentiality and disclosure laws of the Commonwealth.

348 h. Ensure that covered employees have access to the services provided by the Ombudsman and that
349 the covered employees receive timely responses from the Ombudsman or his representatives to the
350 inquiries.

351 i. Report annually on his activities to the standing committees of the General Assembly having
352 jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of
353 each year.

354 M. 1. The plan established by the Department of Human Resource Management shall not refuse to
355 accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon
356 by a covered employee.

357 2. For purposes of this subsection, "assignment of benefits" means the transfer of dental care
358 coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be
359 effective until the covered employee notifies the plan in writing of the assignment.

360 N. Any group health insurance plan established by the Department of Human Resource Management
361 that contains a coordination of benefits provision shall provide written notification to any eligible
362 employee as a prominent part of its enrollment materials that if such eligible employee is covered under
363 another group accident and sickness insurance policy, group accident and sickness subscription contract,
364 or group health care plan for health care services, that insurance policy, subscription contract or health
365 care plan may have primary responsibility for the covered expenses of other family members enrolled
366 with the eligible employee. Such written notification shall describe generally the conditions upon which

the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan which coverage would have primary responsibility for the covered expenses of each family member.

O. 1. The plan established by the Department of Personnel and Training shall not prohibit any employee receiving health care services furnished thereunder from selecting the provider of his choice to furnish such benefits. This right of selection extends to and includes providers that are outside providers and that have previously notified the plan, by facsimile or otherwise, of their agreement to accept reimbursement for their services at rates applicable to providers that are members of the provider panel, including any cost sharing arrangement consistently imposed by the plan, as payment in full. The plan shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the provider and ensure prompt verification to the provider of the terms of reimbursement. In no event shall any covered employee receiving covered health care services from an outside provider that has submitted a reimbursement agreement be responsible for amounts that may be charged by the outside provider in excess of the cost sharing arrangement and the plan's reimbursement applicable to the members of the provider panel.

2. The plan shall not impose upon any covered employee receiving health care services furnished under the plan:

a. Any cost sharing arrangement or condition that is not equally imposed upon all covered employees in the same benefit category, class or copayment level, whether or not such benefits are furnished by providers who are outside providers;

b. Any monetary penalty that would affect or influence any covered employee's choice of provider; or

c. Any reduction in allowable reimbursement for health care services related to utilization of providers who are outside providers.

3. The plan shall not: (i) deny immediate access to electronic claims filing to a provider that is not a member of the provider panel and that has complied with subdivision 4 of this subsection or (ii) require a covered employee receiving health care services to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on members of the provider panel.

4. Any provider who wishes to be covered by this subsection shall, if requested to do so in writing by the plan, within thirty days of the plan's receipt of the request, execute and deliver to the plan the agreement that the plan requires all of its members of the provider panel to execute. Any provider who fails to timely execute and deliver such agreement shall not be covered by this subsection with respect to the plan unless and until the provider executes and delivers the agreement.

5. As used in this subsection, the terms "cost sharing arrangement," "health care services," "outside provider," "provider," and "provider panel" shall have the same meanings ascribed thereto in § 38.2-3407.17.

§ 38.2-3407.17. Health care services; freedom of choice.

A. As used in this section:

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies that is subject to Chapter 34 (§ 38.2-3400 et seq.) of this title, including any health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209;

2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services plans that are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;

3. Any health maintenance organization licensed under this title that provides or arranges for the provision of one or more health care plans that are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;

4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans that are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and

5. Any other person licensed under this title that provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels that are subject to regulation as the business of insurance under this title.

"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service that is not paid by the carrier and for which the covered person is responsible.

"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the covered person to the provider toward the allowable charge as a condition of the receipt of specific health care items and services.

"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the covered person as a condition to or consequence of the receipt of covered

428 *health care services.*

429 *"Covered person" means an individual, whether a policyholder, subscriber, enrollee, or member of a*
430 *managed care health insurance plan, who is entitled to health care services provided, arranged for, paid*
431 *for or reimbursed pursuant to a managed care health insurance plan.*

432 *"Deductible" means the dollar amount of a covered item or service that the covered person is*
433 *obligated to pay before benefits are payable under the carrier's policy or contract with the group*
434 *contract holder.*

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

437 *"Managed care health insurance plan" or "MCHIP" means an arrangement for the delivery of health*
438 *care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs*
439 *of health care services for a covered person on a prepaid or insured basis that (i) contains one or more*
440 *incentive arrangements, including any credentialing requirements intended to influence the cost or level*
441 *of health care services between the health carrier and one or more providers with respect to the*
442 *delivery of health care services, and (ii) requires or creates benefit payment differential incentives for*
443 *covered persons to use providers that are directly or indirectly managed, owned, under contract with or*
444 *employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or*
445 *health carrier that offers preferred provider policies or contracts as defined in § 38.2-3407 or preferred*
446 *provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more*
447 *MCHIPs. A single managed care health insurance plan may encompass multiple products and multiple*
448 *types of benefit payment differentials; however, a single managed care health insurance plan shall*
449 *encompass only one provider panel or set of provider panels.*

450 *"Outside provider" means a provider that is not a member of the managed care health insurance*
451 *plan's provider panel.*

452 *"Provider" means any physician, hospital or other person, including optometrists and clinical*
453 *psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health*
454 *care services.*

455 *"Provider panel" means the participating providers or referral providers, or network thereof, who*
456 *have a contract, agreement or arrangement with a carrier, either directly or through an intermediary,*
457 *and who have agreed to provide items or services to covered persons of the carrier's managed care*
458 *health insurance plan.*

459 *B. Notwithstanding any provision of § 38.2-3407 to the contrary, no carrier operating a managed*
460 *care health insurance plan in this Commonwealth shall prohibit any covered person receiving health*
461 *care services furnished thereunder from selecting the provider of his choice to furnish health care*
462 *services. This right of selection extends to and includes outside providers that have previously notified*
463 *the carrier, by facsimile or otherwise, of their agreement to accept reimbursement for their health care*
464 *services at the rates applicable to providers that are members of the MCHIP's provider panel, including*
465 *any cost sharing arrangement consistently imposed by the carrier, as payment in full.*

466 *C. Each carrier shall permit prompt electronic or telephonic transmittal of the reimbursement*
467 *agreement by the provider and ensure prompt verification to the provider of the terms of reimbursement.*
468 *In no event shall any covered person receiving covered health care services from an outside provider*
469 *that has submitted a reimbursement agreement be responsible for cost sharing arrangement amounts*
470 *that may be charged by the outside provider in excess of the cost sharing arrangement amounts*
471 *applicable to all members of the MCHIP's provider panel.*

472 *D. No such carrier shall impose upon any covered person receiving health care services furnished*
473 *under any MCHIP:*

474 *1. Any cost sharing arrangement or condition that is not equally imposed upon all covered persons*
475 *in the same benefit category, class or copayment level, whether or not such benefits are furnished by*
476 *outside providers;*

477 *2. Any cost sharing arrangement or penalty that would affect or influence any covered person's*
478 *choice of provider; or*

479 *3. Any reduction in allowable reimbursement for health care services related to utilization of outside*
480 *providers.*

481 *E. No such carrier, with respect to any covered person receiving health care services furnished*
482 *under any MCHIP, shall: (i) deny immediate access to electronic claims filing to an outside provider*
483 *that has complied with subsection F of this section or (ii) require a covered person receiving health*
484 *care services to make payment at point of service, except to the extent such conditions and penalties are*
485 *similarly imposed on members of the MCHIP's provider panel.*

486 *F. Any provider who wishes to be covered by this section shall, if requested to do so in writing by a*
487 *carrier, within thirty days of the provider's receipt of the request, execute and deliver to the carrier, the*
488 *contract or agreement that the carrier requires all of the members of its provider panel to execute. Any*
489 *provider who fails to timely execute and deliver such contract or agreement shall not be covered by this*

section with respect to that carrier unless and until the provider executes and delivers the contract or agreement.

G. The provisions of this section shall not be applicable to the provision of pharmacy benefits.

H. This section shall apply to policies, contracts, and plans delivered, issued for delivery, or renewed by carriers in this Commonwealth on or after July 1, 2001.

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

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 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 38.2-3407.17, 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, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3543.2, 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 et seq.) 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, 38.2-209 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.), §§ 32.2-1017 through 38.2-1023, §§ 38.2-1057, Articles 2 (§ 38.2-1306 et seq.), 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 38.2-3407.17, 38.2-3411.2, 38.2-3411.3, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.12, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, 38.2-3514.1, 38.2-3514.2, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 52 (§§ 38.2-5200 et seq.), Chapter 55 (§§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), 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.

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, 38.2-209 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.), §§ 38.2-1017 through 38.2-1023 §§ 38.2-1057, Articles 2 (§ 38.2-1306 et seq.), 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 38.2-3407.17, 38.2-3411.2, 38.2-3411.3, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.12, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of

§ 38.2-3503, subdivision 8 of § 38.2-3504, 38.2-3514.1, 38.2-3514.2, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 52 (§§ 38.2-5200 et seq.), Chapter 55 (§§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) 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.

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.

§ 38.2-4509. 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, 38.2-209 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, 38.2-3407.17, 38.2-3415, 38.2-3541, 38.2-3600 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) 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.

2. That § 38.2-3407.12 of the Code of Virginia is repealed.