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HOUSE BILL NO. 1958

Offered January 12, 2011

Prefiled January 11, 2011

A BILL to amend and reenact §§ 32.1-137.1, 32.1-137.6, 32.1-137.7, 32.1-137.9, 32.1-137.13 through 32.1-137.16, 38.2-508.5, 38.2-3406.1, 38.2-3406.2, 38.2-3407.11, 38.2-3411.1, 38.2-3418.5, 38.2-3432.3, 38.2-3500, 38.2-3525, 38.2-4216.1, and 38.2-4312.3 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-137.15:1 and by adding in Chapter 34 of Title 38.2 an article numbered 6, consisting of sections numbered 38.2-3438 through 38.2-3446, relating to health insurance plans; market reforms.

Patron—Rust

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.1, 32.1-137.6, 32.1-137.7, 32.1-137.9, 32.1-137.13 through 32.1-137.16, 38.2-508.5, 38.2-3406.1, 38.2-3406.2, 38.2-3407.11, 38.2-3411.1, 38.2-3418.5, 38.2-3432.3, 38.2-3500, 38.2-3525, 38.2-4216.1, and 38.2-4312.3 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-137.15:1 and by adding in Chapter 34 of Title 38.2 an article numbered 6, consisting of sections numbered 38.2-3438 through 38.2-3446, as follows:

§ 32.1-137.1. Definitions.

As used in this and the following article, unless the context indicates otherwise:

"Agent" or "insurance agent," when used without qualification, means an individual, partnership, limited liability company, or corporation that solicits, negotiates, procures or effects contracts of insurance or annuity in this Commonwealth.

"Bureau of Insurance" means the State Corporation Commission acting pursuant to Title 38.2.

"Complaint" means any written *or oral* communication from a covered person ~~primarily~~ expressing a grievance *involving an urgent care request submitted by or on behalf of a covered person regarding:*

1. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

2. Claims payment, handling or reimbursement for health care services; or

3. Matters pertaining to the contractual relationship between a covered person and a managed care health insurance plan.

"Covered person" means an individual residing in the Commonwealth, whether a policyholder, subscriber, enrollee, 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 under Title 38.2.

"Managed care health insurance plan" means an arrangement for the delivery of health care in which a health carrier as defined in § 38.2-5800 undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more managed care health insurance plans. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Managed care health insurance plan licensee" means a health carrier subject to licensure by the Bureau of Insurance under Title 38.2 who is responsible for a managed care health insurance plan in accordance with Chapter 58 (§ 38.2-5801 et seq.) of Title 38.2.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, other organization, partnership, receiver, reciprocal or

inter-insurance exchange, trustee or society.

§ 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~~ *determinations* 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 Human Resource Management 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.

§ 32.1-137.7. Definitions.

As used in this article:

"Adverse ~~decision~~ *determination*" means a ~~utilization review~~ determination by ~~the~~ *a health carrier or its designee* utilization review ~~entity~~ *organization* that ~~a~~ *an admission, availability of care, continued stay, or other* health *care* service ~~rendered or proposed to be rendered was or is not medically necessary, when such determination may result in noncoverage of the health service or health services~~ *that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirement for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment of the service is therefore denied, reduced, or terminated. Adverse determinations include coverage rescissions.* When the policy, contract, plan, certificate, or evidence of coverage includes coverage for prescription drugs and the health service rendered or proposed to be rendered is a prescription for the alleviation of cancer pain, any adverse ~~decision~~ *determination* shall be made within ~~twenty-four~~ *24* hours of the request for coverage.

"Commission" means the Virginia State Corporation Commission.

"Covered person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health

insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Evidence of coverage" includes any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

"Final adverse ~~decision~~ *determination*" means a utilization review determination made by a physician advisor or peer of the treating health care provider in a reconsideration of an adverse ~~decision~~ *determination*, and upon which a provider or patient may base an appeal.

"Medical director" means a physician licensed to practice medicine in the Commonwealth of Virginia who is an employee of a utilization review organization responsible for compliance with the provisions of this article.

"Peer of the treating health care provider" means a physician or other health care professional who holds a nonrestricted license in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"Physician advisor" means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to a private review agent or a utilization review entity in connection with its utilization review activities.

"Private review agent" means a person or entity performing utilization reviews, except that the term shall not include the following entities or employees of any such entity so long as they conduct utilization reviews solely for subscribers, policyholders, members or enrollees:

1. A health maintenance organization authorized to transact business in Virginia; or

2. A health insurer, hospital service corporation, health services plan or preferred provider organization authorized to offer health benefits in this Commonwealth.

"Rescission" means cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

"Treating health care provider" or "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 article, "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 not include (i) any review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services, (ii) any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital, 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 of insurance covering any classes of insurance defined in §§ 38.2-117 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through 38.2-132 and 38.2-134.

"Utilization review entity" or "entity" means a person or entity performing utilization review.

"Utilization review plan" or "plan" means a written procedure for performing review.

§ 32.1-137.9. Requirements and standards for utilization review entities.

A. Each entity shall establish reasonable and prudent standards and criteria to be applied in utilization review determinations with input from physician advisors representing major areas of specialty and certified by the boards of the various American medical specialties. Such standards shall be objective, clinically valid, and compatible with established principles of health care. Such standards shall further be established so as to be sufficiently flexible to allow deviations from norms when justified on case-by-case bases.

The entity shall make available to any provider or covered person, upon written request, a list of such physician advisors and their major areas of specialty, as well as the standards and criteria established in accordance with this section except as prohibited in accordance with copyright laws.

B. An adverse ~~decision~~ *determination* shall be made only in accordance with § 32.1-137.13.

C. Each entity shall have a process for reconsideration of an adverse ~~decision~~ *determination* in accordance with § 32.1-137.14 and an appeals process in accordance with § 32.1-137.15.

D. Each entity shall make arrangements to use the services of physician advisors who are specialists in the various categories of health care on "per need" or "as needed" bases in conducting utilization review.

E. Each entity shall have review staff who are properly qualified, trained and supervised, and supported by a physician advisor, to carry out its review determinations.

F. Each entity shall notify its covered persons of the review process, including the appeals process, and shall so notify the covered person's provider upon written request by the provider. An Evidence of Coverage shall contain a clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of the process for reconsideration of an adverse ~~decision~~ *determination* rendered under § 32.1-137.13, as required by § 32.1-137.14, and the process for appeal from a final adverse ~~decision~~ *determination* under § 32.1-137.15.

G. Each entity shall communicate its utilization review decision no later than two business days after receipt by the entity of all information necessary to complete the review.

H. Each entity shall have a representative, authorized to approve utilization review determinations, available to covered persons and providers in accordance with § 32.1-137.11.

I. The Commissioner shall have the right to determine that an entity has complied with the requirement that the entity establish reasonable and prudent requirements and standards pursuant to this section.

§ 32.1-137.13. Adverse determination.

A. The treating provider shall be notified in writing of any adverse ~~decision~~ *determination* within two working days of the ~~decision~~ *determination*; however, the treating provider shall be notified orally by telephone within 24 hours of any adverse ~~decision~~ *determination* for a prescription known to be for the alleviation of cancer pain. Any such notification shall include instructions for the provider on behalf of the covered person to (i) seek a reconsideration of the adverse ~~decision~~ *determination* pursuant to § 32.1-137.14, including the contact name, address, and telephone number of the person responsible for making the adverse ~~decision~~ *determination*, and (ii) seek an appeal of the adverse ~~decision~~ *determination* pursuant to § 32.1-137.15, including the contact name, address, and telephone number to file and perfect such appeal.

B. No entity shall render an adverse ~~decision~~ *determination* unless it has made a good faith attempt to obtain information from the provider. At any time before the entity renders its ~~decision~~ *determination*, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating health care provider who represents the entity. For any adverse ~~decision~~ *determination* relating to a prescription to alleviate cancer pain, a physician advisor shall review the issue of medical necessity with the provider.

§ 32.1-137.14. Reconsideration of adverse determination.

A. A treating provider may request reconsideration of an adverse ~~decision~~ *determination* pursuant to this section or may appeal ~~an~~ *a final* adverse ~~decision~~ *determination* pursuant to § 32.1-137.15. Any reconsideration of an adverse ~~decision~~ *determination* shall only be requested by the treating provider on behalf of the covered person. A decision on reconsideration 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 or peer of the treating health care provider on the panel.

B. The treating provider on behalf of the covered person shall be (i) notified verbally at the time of the determination of the reconsideration of the adverse ~~decision~~ *determination* and in writing following the determination of the reconsideration of the adverse ~~decision~~ *determination*, in accordance with § 32.1-137.9, including the criteria used and the clinical reason for the adverse ~~decision~~ *determination* and the alternate length of treatment of the alternate treatment setting or settings, if any, that the entity deems to be appropriate, and (ii) notified verbally at the time of the determination of the reconsideration of the adverse ~~decision~~ *determination* of the process for an appeal of the determination pursuant to § 32.1-137.15 and the contact name, address, and telephone number to file and perfect an appeal. If the treating provider on behalf of the covered person requests that the adverse ~~decision~~ *determination* be reviewed by a peer of the treating provider at any time during the reconsideration process, the request for reconsideration shall be vacated and considered an appeal pursuant to § 32.1-137.15. In such cases, the covered person shall be notified that the reconsideration has been vacated and an appeal initiated, all documentation and information provided or relied upon during the reconsideration process pursuant to this section shall be converted to the appeal process, and no additional actions shall be required of the treating provider to perfect the appeal.

C. Any reconsideration shall be rendered and the decision provided to the treating provider and the covered person in writing within 10 working days of receipt of the request for reconsideration.

§ 32.1-137.15. Final adverse determination; appeal.

A. Each entity shall establish an appeals process, including a process for expedited appeals, to consider any final adverse ~~decision~~ *determination* 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 60 working days after receiving the required documentation. The ~~decision~~ *determination* shall be in writing and shall state the criteria used and the clinical reason for the ~~decision~~ *determination*. 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~~*determinations* 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~~ *determination*. An expedited appeals process of no more than 24 hours shall be established and conducted by telephone to consider any final adverse ~~decision~~ *determination* 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 in the same or similar specialty as the treating health care provider, 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~~ *determination* on appeal shall (i) not have participated in the adverse ~~decision~~ *determination* 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~~ *determination*, 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~~ *determination* or adverse reconsideration is made and the treating health care provider believes that the ~~decision~~ *determination* warrants an immediate appeal, the treating health care provider shall have the opportunity to appeal the adverse ~~decision~~ *determination* 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~~ *determination* or adverse reconsideration relating to a prescription to alleviate cancer pain.

The ~~decision~~ *determination* 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~~ *determination* 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~~ *determination*, reconsideration, or final adverse ~~decision~~ *determination* 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.

§ 32.1-137.15:1. Coverage rescissions.

A. If an adverse determination is a rescission, the MCHIP shall provide, in the advance notice of the rescission determination required to be provided under § 38.2-3441 and in addition to any applicable disclosures required under applicable law or regulation:

1. Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

2. An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

3. Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a complaint to request a reconsideration of the adverse determination to rescind coverage pursuant to § 32.1-137.14;

4. A description of the health carrier's complaint system established pursuant to § 32.1-137.6, including any time limits applicable to those procedures; and

5. The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

B. A managed care health insurance plan may provide the notice required under this section in writing or electronically.

§ 32.1-137.16. Records.

Every entity subject to Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 ~~of~~ ~~this~~ ~~title~~ and this article shall maintain or cause to be maintained, in writing and at a location accessible to employees of the Department, records of review procedures; the health care qualifications of the entity's staff; the criteria used by the entity to make its ~~decisions~~ *determinations*; records of complaints received, including the manner in which the complaints were resolved; the number and type of adverse ~~decisions,~~ *determinations* and reconsiderations; the number and outcome of final adverse ~~decisions~~ *determinations* and appeals thereof, including a separate record for expedited appeals; and procedures to ensure confidentiality of medical records and personal information. Records of complaints under Article 1.1 (§ 32.1-137.1 et seq.) ~~of~~ ~~this~~ ~~chapter~~ shall be maintained from the date of the entity's last examination and for no less than ~~five~~ *six* years.

Every entity subject to utilization review under this article shall provide, upon request of the Commissioner, data and records pertaining to utilization review from which patient and provider identifiers have been removed. Records shall be maintained or caused to be maintained by the utilization review entity for a period of ~~five~~ *six* years, and all such records shall be subject to examination by the Commissioner or his designee.

§ 38.2-508.5. Re-underwriting individual under existing group or individual accident and sickness insurance policy prohibited; exceptions.

A. No premium increase, including a reduced premium increase in the form of a discount, may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such premium increase is determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

B. No reduction in benefits may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such reduction in benefits is determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

C. No modifications to contractual terms and conditions may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such modifications to contractual terms and conditions are determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

D. This section shall not prohibit adjustments to premium, rescission of, or amendments to the insurance contract in the following circumstances:

1. When an insurer learns of information subsequent to issuing the policy or certificate that was not disclosed in the underwriting process and that, had it been known, would have resulted in a higher premium level or denial of coverage. Any adjustment to premium or rescission of coverage made for this reason may be made only to extent that it would have been made had the information been disclosed in the application process, and shall not be imposed beyond any period of incontestability, or beyond any time period proscribing an insurer from asserting defenses based upon misstatements in applications, as otherwise may be provided by applicable law. Any such rescission shall be consistent with § 38.2-3430.3 regarding guaranteed availability.

2. When an insurer provides a lifestyle-based good health discount based upon an individual's adherence to a healthy lifestyle and this discount is not based upon a specific health condition or diagnosis.

3. When an insurer removes waivers or riders attached to the policy at issue that limit coverage for

specific named pre-existing medical conditions.

E. For purposes of this section, re-underwriting means the reevaluation of any health-status-related factor of an individual for purposes of adjusting premiums, benefits or contractual terms as provided in subsections A, B, and C ~~of this section~~.

F. The provisions of this section shall not apply to individual health insurance coverage issued to members of a bona fide association, as defined in subsection B of § 38.2-3431, where coverage is available to all members of the association and eligible dependents of such members without regard to any health-status-related factor.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3406.1. Application of requirements that policies offered by small employers include state-mandated health benefits.

A. As used in this section:

"Eligible individual" means an individual who is employed by a small employer and has satisfied applicable waiting period requirements.

"Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under a group policy of accident and sickness insurance, hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, which coverage is subject to this title or is provided under a plan regulated under the Employee Retirement Income Security Act of 1974.

"Health insurer" means any insurance company that issues accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, a corporation that provides accident and sickness subscription contracts, or any health maintenance organization that provides a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services, that is licensed to engage in such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144(b)(2)).

"Small employer" means, with respect to a calendar year and a plan year, an employer located in the Commonwealth that employed at least two but not more than 50 eligible individuals on business days during the preceding calendar year and who employs at least two eligible individuals on the date a policy under this section becomes effective.

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16, 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, or § 38.2-4221. For purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

B. Notwithstanding any statute, rule, or regulation to the contrary, and for the purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a group accident and sickness subscription contract providing health insurance coverage for eligible individuals; and a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services that is offered, sold, or issued by a health insurer to a small employer:

1. Shall not be required to include coverage, or the offer of coverage, for any state-mandated health benefit, except for:

a. Coverage for mammograms pursuant to § 38.2-3418.1;

b. Coverage for pap smears pursuant to § 38.2-3418.1:2;

c. Coverage for PSA testing pursuant to § 38.2-3418.7; and

d. Coverage for colorectal cancer screening pursuant to § 38.2-3418.7:1.

2. May include any, or none, of the state-mandated health benefits not otherwise noted in subdivision B 1 as the health insurer and the small employer shall agree.

Notwithstanding any provision of this section to the contrary, if any plan authorized by this section includes and offers health care services covered by the plan that may be legally rendered by a health care provider listed in § 38.2-3408, that plan shall allow for the reimbursement of such covered services

when rendered by such provider. Unless otherwise provided in this section, this provision shall not require any benefit be provided as a covered service.

C. Any application and any enrollment form used in connection with coverage under this section shall prominently disclose that the policy, contract, or evidence of coverage is not required to provide state-mandated health benefits, shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide, and shall clearly describe all eligibility requirements.

D. A policy form, subscription contract, or evidence of coverage issued under this section to a small employer shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide. Such disclosure shall also be included in certificate forms or other evidences of coverage furnished to each participant. Health insurers proposing to issue forms providing coverage under this section shall clearly disclose the intended purposes for such policies, contracts, or evidences of coverage when submitting the forms to the Commission for approval in accordance with § 38.2-316.

E. The Commission shall adopt any regulations necessary to implement this section.

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3406.2. Capped benefits under insurance policies and contracts.

A. Nothing in this chapter or Chapters 35 (§ 38.2-3500 et seq.) or 42 (§ 38.2-4200 et seq.) shall prohibit the offering, sale, or issuance of accident and sickness insurance policies or subscription contracts that cap or limit the total annual or lifetime benefits provided under an accident and sickness insurance policy or subscription contracts at specified dollar amounts.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3407.11. Access to obstetrician-gynecologists.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts or plans, include coverage for obstetrical or gynecological services, shall permit any female of age ~~thirteen~~ *13* or older covered thereunder direct access, as provided in subsection B, to the health care services of a participating obstetrician-gynecologist ~~(i)~~ *(a)* authorized to provide services under such policy, contract or plan and ~~(ii)~~ *(b)* selected by such female.

B. An annual examination, and routine health care services incident to and rendered during an annual visit, may be performed without prior authorization from the primary care physician. However, additional health care services may be provided subject to the following:

1. Consultation, which may be by telephone or electronically, with the primary care physician for follow-up care or subsequent visits;

2. Prior consultation and authorization by the primary care physician before the patient may be directed to another specialty provider; and

3. Prior authorization by the insurer, corporation, or health maintenance organization for proposed inpatient hospitalization or outpatient surgical procedures.

C. For the purpose of this section, "health care services" means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system and breasts and in performing annual screening and immunization for disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. The term includes services provided by nurse practitioners, physician assistants, and certified nurse midwives in collaboration with the obstetrician-gynecologists providing care to individuals covered under any such policies, contracts or plans.

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

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.

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, or to short-term nonrenewable policies of not more than six months' duration.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3411.1. Coverage for child health supervision services.

A. Every individual or group accident and sickness insurance policy, subscription contract providing coverage under a health services plan, or evidence of coverage of a health care plan delivered or issued for delivery in the Commonwealth or renewed, reissued, or extended if already issued, shall offer and make available coverage under such policy or plan for child health supervision services to provide for the periodic examination of children covered under such policy or plan.

B. As used in this section, the term "child health supervision services" means the periodic review of a child's physical and emotional status by a licensed and qualified physician or pursuant to a physician's supervision. A review shall include but not be limited to a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards.

C. Each such policy or plan, offering and making available such coverage, shall, at a minimum, provide benefits for child health supervision services at approximately the following age intervals: birth, two months, four months, six months, nine months, ~~twelve~~ *12* months, ~~fifteen~~ *15* months, ~~eighteen~~ *18* months, two years, three years, four years, five years, and six years. A policy or plan may provide that child health supervision services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit.

D. Benefits for coverage for child health supervision services shall be exempt from any copayment, coinsurance, deductible, or other dollar limit provision in the policy or plan. Such exemption shall be expressly stated on the policy, plan, rider, endorsement, or other attachment providing such coverage.

E. The premiums for such coverage shall take into consideration (i) the cost of providing such coverage, (ii) cost savings realized or likely to be realized as a consequence of such coverage, (iii) a reasonable profit for the insurer, and (iv) any other relevant information or data the Commission deems appropriate.

F. This section shall not apply (i) to any insurer or health services plan having fewer than 1,000 covered individuals insured or covered in Virginia or less than $500,000 in premiums in Virginia as of its last annual statement, (ii) to short-term travel or accident only policies, (iii) to short-term nonrenewable policies of not more than six months' duration, or (iv) to specified disease, hospital indemnity or other limited benefit policies issued to provide supplemental benefits to a policy providing primary care benefits.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3418.5. Coverage for early intervention services.

A. Notwithstanding the provisions of § 38.2-3419, each 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; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for medically necessary early intervention services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998. Such coverage shall be limited to a benefit of $5,000 per insured or member per policy or calendar year and, except as set forth in subsection C, shall be subject to such dollar limits, deductibles and coinsurance factors as are no less favorable than for physical illness generally.

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

C. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer, corporation or health maintenance organization to or on behalf of the insured or member during the insured's or member's lifetime.

D. "Financial costs," as used in this section, shall mean any copayment, coinsurance, or deductible in the policy or plan. Financial costs may be paid through the use of federal Part H program funds, state general funds, or local government funds appropriated to implement Part H services for families who may refuse the use of their insurance to pay for early intervention services due to a financial cost.

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

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3432.3. Limitation on preexisting condition exclusion period.

A. Subject to subsection B, a health insurer offering health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting limitation only if:

1. For group health insurance coverage, such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

2. For individual health insurance coverage, such exclusion relates to a condition that, during a 12-month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received within 12 months immediately preceding the effective date of coverage;

3. Such exclusion extends for a period of not more than 12 months (or 12 months in the case of a late enrollee) after the enrollment date; and

4. The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

B. Exceptions:

1. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

3. A health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, except in the case of individual health insurance coverage for a person who is not considered an eligible individual, as defined in § 38.2-3430.2, in which case the health insurance issuer may impose a preexisting condition exclusion for a pregnancy existing on the effective date of coverage;

4. Subdivisions 1 and 2 of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage; and

5. Subdivision A 4 ~~of this section~~ shall not apply to health insurance coverage offered in the individual market on a "guarantee issue" basis without regard to health status including open enrollment policies or contracts issued pursuant to § 38.2-4216.1 and policies, contracts, certificates or evidences of coverage issued through a bona fide association or to students through school sponsored programs at a college or university unless the person is an eligible individual as defined in § 38.2-3430.2.

C. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

D. For purposes of subdivision B 4 and subsection C, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period under subsection C.

E. Methods of crediting coverage:

1. Except as otherwise provided under subdivision 2 of this subsection, a health insurance issuer offering group health coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period;

2. A health insurance issuer offering group health insurance coverage may elect to count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits rather than as provided under subdivision 1 of this subsection. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category;

3. In the case of an election with respect to a group plan under subdivision 2 of this subsection (whether or not health insurance coverage is provided in connection with such plan), the plan shall: (i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election and (ii) include in such statements a description of the effect of this election; and

4. In the case of an election under subdivision 2 of this subsection with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall: (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election and (ii) include in such statements a description of the effect of such election.

F. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection G or in such other manner as may be specified in federal regulations.

G. A health insurance issuer offering group health insurance coverage shall provide for certification of the period of creditable coverage:

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

2. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under such provision; and

3. At the request, or on behalf of, an individual made not later than 24 months after the date of cessation of the coverage described in subdivision 1 or 2 of this subsection, whichever is later. The certification under subdivision 1 of this subsection may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

H. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

I. In the case of an election described in subdivision E 2 by a health insurance issuer, if the health insurance issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subsection F:

1. Upon request of such health insurance issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting group insurance issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

2. Such entity may charge the requesting health insurance issuer for the reasonable cost of disclosing such information.

J. A health insurance issuer offering group health insurance coverage shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time;

3. The employee's or dependent's coverage described in subdivision 1 of this subsection: (i) was under a COBRA continuation provision and the coverage under such provision was exhausted or (ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated; and

4. Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in *clause (i) of* subdivision 3 ~~(i)~~ of this subsection or termination of coverage or employer contribution described in *clause (ii) of* subdivision 3 ~~(ii)~~ of this subsection.

K. If: (i) a health insurance issuer makes coverage available with respect to a dependent of an individual; (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and (iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer shall provide for a dependent special enrollment period described in subsection L ~~of this section~~ during

which the person (or, if not otherwise enrolled, the individual) may also be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

L. A dependent special enrollment period under this subsection shall be a period of not less than 30 days and shall begin on the later of:

1. The date dependent coverage is made available; or

2. The date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subsection K.

M. If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

2. In the case of a dependent's birth, as of the date of such birth; or

3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

N. A late enrollee may be excluded from coverage for up to 12 months or may have a preexisting condition limitation apply for up to 12 months; however, in no case shall a late enrollee be excluded from some or all coverage for more than 12 months. An eligible employee or dependent shall not be considered a late enrollee if all of the conditions set forth below in subdivisions 1 through 4 are met or one of the conditions set forth below in subdivision 5 or 6 is met:

1. The individual was covered under a public or private health benefit plan at the time the individual was eligible to enroll.

2. The individual certified at the time of initial enrollment that coverage under another health benefit plan was the reason for declining enrollment.

3. The individual has lost coverage under a public or private health benefit plan as a result of termination of employment or employment status eligibility, the termination of the other plan's entire group coverage, death of a spouse, or divorce.

4. The individual requests enrollment within 30 days after termination of coverage provided under a public or private health benefit plan.

5. The individual is employed by a small employer that offers multiple health benefit plans and the individual elects a different plan offered by that small employer during an open enrollment period.

6. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan, the minor is eligible for coverage and is a dependent, and the request for enrollment is made within 30 days after issuance of such court order.

However, such individual may be considered a late enrollee for benefit riders or enhanced coverage levels not covered under the enrollee's prior plan.

O. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

Article 6.

Federal Market Reforms.

§ 38.2-3438. Definitions.

As used this article, unless the context requires a different meaning:

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, or foster child.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition: (i) a medical screening examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd(e)(3)) to stabilize the patient.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"Essential health benefits" include the following general categories and the items and services covered within the categories in accordance with regulations issued pursuant to the PPACA: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices.

"Facility" means an institution providing health care related services or a health care setting, including but not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Grandfathered plan" means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010, for as long as such plan maintains that status in accordance with federal law.

"Group health insurance coverage" means health insurance coverage offered in connection with a group health benefit plan.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care, and includes items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.).

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance. A health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health benefit plan.

"Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Medical care" means amounts paid for:

1. The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. Transportation primarily for and essential to services referred to in subdivision 1; and

3. Insurance covering services referred to in subdivisions 1 and 2.

"Network" means the group of participating providers providing services to a managed care plan.

"Open enrollment" means, with respect to individual health insurance coverage, the period of time during which any individual under the age of 19 has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and must be accepted for coverage under the plan without regard to a preexisting condition exclusion.

"Participating health care professional" means a health care professional who, under contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to

covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

"Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. "Preexisting condition exclusion" also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination given to an individual, or review of medical records relating to the pre-enrollment period.

"Primary care health care professional" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

2. When the health benefit plan covers only active employees and, if applicable, dependents and those covered under continuation coverage provisions, the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

"Stabilize" means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

§ 38.2-3439. Dependent coverage for individuals to age 26.

A. Notwithstanding any provision of § 38.2-3500, 38.2-3525, or any other section of this title to the contrary, a health carrier that makes available dependent coverage for a child shall make that coverage available for a child until such child attains the age of 26.

1. A health carrier shall not define "dependent" for purposes of eligibility for dependent coverage for a child other than in terms of a relationship between a child and the covered person.

2. A health carrier shall not deny or restrict coverage for a child who has not attained the age of 26 based on the presence or absence of the child's financial dependency on the covered person, residency with the covered person, marital status, student status, employment, or any combination of those factors.

3. Nothing in this section shall be construed to require a health carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

B. Any child whose coverage ended, who was denied coverage, or who was not eligible for group or individual health insurance coverage under a health benefit plan because, under the terms of such plan, the availability of dependent coverage of a child ended before the attainment of the age of 26, shall be given written notice of the opportunity to enroll.

1. The health carrier shall give such child written notice of the opportunity to enroll not later than the first day of the next plan year or policy year, and shall provide for an enrollment period that continues for at least 30 days.

2. The written notice of opportunity to enroll shall include a statement that a child is eligible to enroll in dependent coverage if coverage ended, coverage was denied, or the child was ineligible for coverage because the availability of dependent coverage for a child ended before the attainment of the age of 26.

a. The notice may be provided to the covered person on behalf of the covered person's child.

b. For group health insurance coverage, the notice may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent.

3. For any child of a covered person who enrolls, the coverage shall take effect not later than the first day of such plan year or policy year.

C. This section shall apply to any health carrier providing individual or group health insurance coverage, except that for plan years beginning before January 1, 2014, a grandfathered group health plan that makes available dependent coverage for a child may exclude a child who has not attained the

age of 26 from coverage only if the child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in § 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

For plan years beginning on or after January 1, 2014, any grandfathered plan shall comply with the requirements of subsections A and B.

§ 38.2-3440. Lifetime and annual limits.

A. Notwithstanding any provision of § 38.2-3406.1, 38.2-3406.2, 38.2-3418.5, or any other section of this title to the contrary, a health carrier offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any covered person.

B. Beginning on January 1, 2014, a health carrier shall not establish any annual limit on the dollar amount of essential health benefits for any covered person.

C. For a plan or policy year beginning prior to January 1, 2014, a health benefit plan may establish an annual limit on the dollar amount of essential health benefits for any covered person, provided the limit is no less than the following:

1. For a plan or policy year beginning after September 22, 2010, but before September 23, 2011, $750,000;

2. For a plan or policy year beginning after September 22, 2011, but before September 23, 2012, $1.25 million; and

3. For a plan or policy year beginning after September 22, 2012, but before January 1, 2014, $2 million.

D. The provisions of this section shall not prevent a health carrier from placing annual or lifetime dollar limits for any covered person on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.

E. For a plan or policy year beginning prior to January 1, 2014, a health benefit plan is exempt from the annual limit requirements if the plan is approved for a waiver from such requirements by the U.S. Department of Health and Human Services, but such exemption only applies for the specified period of time that the waiver is applicable.

1. If a health benefit plan receives a waiver from the U.S. Department of Health and Human Services, the health carrier shall notify prospective applicants and affected policyholders and the Commission within 30 days of receipt of the waiver.

2. Within 30 days of when the waiver expires or is otherwise no longer in effect, the health carrier shall notify affected policyholders.

F. If an individual's benefits under a health benefit plan ended by reason of reaching a lifetime limit on the dollar amount of benefits, the health carrier shall provide such individual written notice that the lifetime limit on the dollar value of benefits no longer applies; and the individual, if still eligible to be covered under the plan, may be reinstated to receive benefits under the plan.

1. If the individual is not enrolled in the plan, or if an enrolled individual is eligible for any other benefit package offered under the plan, the health benefit plan shall provide an opportunity for the individual to enroll in any benefit packages offered under the plan for a period of at least 30 days.

2. For individual health insurance coverage, an individual is not entitled to reinstatement under the health benefit plan if the individual reached his lifetime limit and the contract is not renewed or is otherwise no longer in effect. Reinstatement shall apply to a family member who reached his lifetime limit in a family plan and other family members remain covered under the plan.

3. The notice and enrollment opportunity under this subsection shall be provided beginning not later than the first day of the next plan year or policy year.

4. The required notice shall be provided to a covered person, or the covered person on behalf of his dependent. For group health insurance coverage, the notice may be included with other enrollment materials that a health carrier distributes to employees, provided the notice is prominently presented with such materials.

5. Reinstatement shall occur not later than the first day of such plan year or policy year.

G. This section shall apply to any health carrier providing individual or group health insurance coverage, except that the prohibition and limits on annual limits shall not apply to a grandfathered plan providing individual health insurance coverage.

§ 38.2-3441. Rescissions.

A. Notwithstanding any provision of § 38.2-508.5 or any other section of this title to the contrary, a health carrier shall not rescind coverage under a health benefit plan after an individual is covered under the plan unless the individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan.

B. A health carrier shall provide at least 30 days' advance written notice to any covered person who would be affected by the proposed rescission of coverage before coverage under the plan may be

rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group.

C. The provisions of this section apply regardless of any applicable contestability period.

D. This section shall apply to any health carrier providing individual or group health insurance coverage, including any grandfathered plan.

§ 38.2-3442. Preventive services.

A. Notwithstanding any provision of § 38.2-3406.1, 38.2-3411.1, or any other section of this title to the contrary, a health carrier shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements such as a copayment, coinsurance, or deductible with respect to the following items and services:

1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration.

B. A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection A after the recommendation or guideline is no longer in effect.

C. A health carrier shall at least annually at the beginning of each new plan year or policy year revise the preventive services covered under its health benefit plans pursuant to this section consistent with the most current recommendations of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines with respect to infants, children, adolescents, and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

D. 1. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service is billed separately or is tracked as individual encounter data separately from the office visit.

2. A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

3. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

E. Nothing in this section shall preclude a health carrier that has a network of providers from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider.

F. This section shall apply to any health carrier providing individual or group health insurance coverage, except for any grandfathered plan.

§ 38.2-3443. Choice of a health care professional.

A. Notwithstanding any provision of § 38.2-3407.11, 38.2-4312.3, or any other section of this title to the contrary, if a health carrier providing individual or group health insurance coverage requires or provides for the designation by a covered person of a participating primary care health care professional, the health carrier shall permit each covered person to designate any participating primary care health care professional who is available to accept the covered person. For a child, a participating health care professional who specializes in pediatrics and is available to accept the child may be designated as the child's primary care health care professional.

B. If a health carrier provides for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier shall not require any person's prior authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The provision of obstetrical and gynecological care, and the ordering of related items and services, shall be treated the same as the primary care health care

professional.

C. A health carrier shall provide notice to a covered person of the terms and conditions of the plan related to the designation of a participating health care professional.

1. Such notice shall be included whenever the health carrier provides a covered person with a summary plan description, policy, certificate, or contract of health insurance.

2. The health carrier may use the model language found in 45 C.F.R. § 147.138(a)(4)(iii) for such notice.

D. This section shall apply to any health carrier providing individual or group health insurance coverage, except for any grandfathered plan.

§ 38.2-3444. Preexisting condition exclusions for individuals under the age of 19.

A. Notwithstanding any provision of § 38.2-3432.3, 38.2-4216.1, or any other section of this title to the contrary, a health carrier providing individual or group health insurance coverage shall not limit or exclude coverage for an individual under the age of 19 by imposing a preexisting condition exclusion on that individual.

B. Where a health carrier offers individual health insurance coverage that only covers individuals under the age of 19, such health carrier may offer coverage continuously throughout the year or during an open enrollment period from April 1 - May 31 or October 1 - November 30 of each calendar year.

C. During an open enrollment period, a health carrier shall not deny or unreasonably delay the issuance of a policy or refuse to issue a policy to an individual who is under the age of 19 on the basis of a preexisting condition.

D. Coverage shall be effective for an individual applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

E. Each health carrier shall provide a prominent public notice on its website and written notice to each covered person at least 90 days prior to the open enrollment period of the open enrollment rights for individuals under the age of 19 and provide information as to how an individual eligible for this open enrollment right may apply for coverage with the health carrier during an open enrollment period.

F. This section shall apply to any health carrier providing individual or group health insurance coverage, including a grandfathered plan for group health insurance coverage, but not including a grandfathered plan for individual health insurance coverage.

§ 38.2-3445. Patient access to emergency services.

Notwithstanding any provision of § 38.2-3407.11, 38.2-4312.3, or any other section of this title to the contrary, if a health carrier providing individual or group health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, the health carrier shall provide coverage for emergency services:

1. Without the need for any prior authorization determination, regardless of whether the emergency services are provided on an in-network or out-of-network basis;

2. Without regard to whether the health care provider furnishing the emergency services is a participating health care provider with respect to such services;

3. If such services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to such services received from an in-network provider;

4. If such services are provided out-of-network, any cost-sharing requirement expressed as copayment amount or coinsurance rate cannot exceed the cost-sharing requirement that would apply if such services were provided in-network. However, an individual may be required to pay the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this section. The health carrier complies with this requirement if the health carrier provides benefits with respect to an emergency service in an amount equal to the greatest of (i) the amount negotiated with in-network providers for the emergency service, or if more than one amount is negotiated, the median of these amounts; (ii) the amount for the emergency service calculated using the same method the health carrier generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable amount; and (iii) the amount that would be paid under Medicare for the emergency service.

A deductible may be imposed with respect to out-of-network emergency services only as a part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum shall apply to out-of-network emergency services; and

5. Without regard to any term or condition of such coverage other than the exclusion of or coordination of benefits or an affiliation or waiting period.

§ 38.2-3446. Applicability of federal law.

A. The provisions of Title I of the PPACA shall apply to any health carrier that delivers or issues for delivery individual or group health insurance coverage in the Commonwealth.

B. The Commission shall implement and enforce applicable provisions of such federal law in accordance with the provisions of this title.

§ 38.2-3500. Form of policy.

A. No individual accident and sickness insurance policy shall be delivered or issued for delivery to any person in this Commonwealth unless:

1. The entire consideration for the policy is expressed in the policy;

2. The time at which the insurance takes effect and terminates is expressed in the policy;

3. The policy insures only one person, except that it may insure eligible family members, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyowner;

4. The exceptions and reductions are set forth in the policy and, except those that are set forth in §§ 38.2-3503 through 38.2-3508, are printed with the benefit provisions to which they apply, or under an appropriate caption, but if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with that benefit provision;

5. Each form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page of the form;

6. It contains no provision making any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless that portion is set forth in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Commission; and

7. It contains a statement about the provisions of subsections A and B of § 32.1-325.2 regarding the status of the Department of Medical Assistance Services as the payor of last resort.

B. If any policy is issued by an insurer domiciled in this Commonwealth for delivery to a person residing in another state, and if the insurance supervisory official of the other state advises the Commission that any such policy is not subject to approval or disapproval by such official, the Commission may by ruling require that such policy meet the standards set forth in this chapter.

C. "Eligible family member" means the (i) spouse, (ii) dependent children, without regard to whether such children reside in the same household as the policyowner, (iii) children under a specified age not greater than ~~nineteen~~ *19* years, and (iv) any person dependent on the policyowner.

D. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3525. Group accident and sickness insurance coverages of spouses, dependent children or other persons.

A. Coverage under a group accident and sickness insurance policy, except a policy issued pursuant to subsection B of § 38.2-3521.1, may be extended to insure:

1. The spouse and any child who is (i) under the age of 19 years, (ii) who is a dependent and under the age of 25 years, or (iii) who is a dependent and a full-time student under 25 years of age, without regard to whether such child resides in the same household as the insured group member, or any class of spouse and dependent children, of each insured group member who so elects; and

2. Any other class of persons as may mutually be agreed upon by the insurer and the group policyholder.

B. The amount of accident and sickness insurance for the spouse, dependent child or other person shall not exceed the amount of accident and sickness insurance for the insured group member.

C. At the insurer's option and subject to the policyholder's election, the coverage for children of the insured group member may be extended beyond the ages established in subsection A. Any such extension of coverage shall be as mutually agreed upon by the insurer and the group policyholder.

D. Notwithstanding the provisions of § 38.2-3538, one certificate may be issued for each insured group member if a statement concerning any spouse's, dependent child's, or other person's coverage is included in the certificate.

E. When a policy provides coverage for a dependent child who is enrolled based upon the child's status as a full-time student and such child is unable due to a medical condition to continue as a full-time student, coverage under the policy for such child nevertheless shall continue in force provided the child's treating physician certifies to the insurer at the time the child withdraws as a full-time student that the child's absence is medically necessary. Coverage for such child shall continue in force until the earlier of (i) the date that is 12 months from the date the child ceases to be a full-time student or (ii) the date the child no longer qualifies as a dependent child under the terms of the group policy. A child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the child is enrolled.

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-4216.1. Open enrollment.

A. A nonstock corporation licensed under this chapter shall make available to citizens of the

Commonwealth an open enrollment program under the terms set forth in this section.

B. As used in this section~~, the term~~:

"Comprehensive accident and sickness contracts" means contracts conforming to the requirements of subsection E which are issued to provide basic hospital and medical-surgical coverage.

"Open enrollment contracts" means comprehensive accident and sickness contracts issued pursuant to an open enrollment program by a nonstock corporation licensed pursuant to this chapter providing coverage to individuals.

C. Each nonstock corporation's open enrollment program shall provide for the issuance of open enrollment contracts without imposition by the nonstock corporation of underwriting criteria whereby coverage is denied or subject to cancellation or nonrenewal, in whole or in part because of any individual's age, health or medical history, or employment status or, if employed, industry or job classification. The open enrollment program shall make open enrollment contracts available to any individual residing in the nonstock corporation's service area within the Commonwealth; however, this subsection shall not require, and no person shall otherwise indicate, that open enrollment contracts are available to any individual who is an employee of an employer which provides, in whole or in part, hospitalization or other health coverage to its employees. Each nonstock corporation's open enrollment program shall make open enrollment contracts available on a year-round basis. The subscription charge for contracts issued pursuant to an open enrollment program shall be reasonable in relation to the benefits and deductibles provided, as determined by the Commission.

D. Each nonstock corporation must prominently advertise the availability of its open enrollment contracts at least ~~twelve~~ *12* times annually in a newspaper or newspapers of general circulation throughout its service area in Virginia. The content and format of such advertising shall be generally approved by the Commission.

E. The Commission may prescribe minimum standards to govern the contents of comprehensive accident and sickness contracts issued pursuant to this section. Such minimum standards shall ensure that such contracts provide health benefit coverage for a comprehensive range of health care needs without qualifying exclusions that fail to protect the subscriber under normal circumstances. Such standards shall ensure that the option of obtaining comprehensive major medical coverage is made available to all individuals included within the definition of "open enrollment contracts" and shall allow for reasonable co-payment provisions, a range of deductibles and a range of coverages available to the consumer. Preexisting conditions may not be excluded from coverage under such contracts; however, waiting periods of up to ~~twelve~~ *12* months for coverage of preexisting conditions shall be allowed. In addition, the Commission may prescribe reasonable minimum standards in order to govern the contents of policies issued to individuals who have converted from group comprehensive accident and sickness contracts to individual coverage because of termination of the individual's eligibility for group coverage.

F. If a nonstock corporation licensed under this chapter elects to discontinue its open enrollment program provided under this section, it may do so only after giving written notice to the Commission of at least ~~twenty-four~~ *24* months in advance of the effective date of termination. Upon termination of the program, the nonstock corporation shall be subject to the license tax provisions of subdivision *A* 1 of ~~subsection A of~~ § 58.1-2501.

G. In addition, a nonstock corporation licensed under this chapter shall provide other public services to the community including health-related educational support and training for those subscribers who, based upon such educational support and training, may experience a lesser need for health-related care and expense.

H. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-4312.3. Patient access to emergency services.

A. A health maintenance organization shall have a system to provide to its members, on a ~~twenty-four-hour~~ *24-hour* basis: (i) access to medical care or (ii) access by telephone to a physician or licensed health care professional with appropriate medical training who can refer or direct a member for prompt medical care in cases where there is an immediate, urgent need or medical emergency. Access to a nonmedical professional who provides appropriate responses to calls from members and providers concerning after-hours care and covered benefits is not sufficient to meet the requirements of this section.

B. A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable copayments, deductibles, or coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which the member presented in the hospital emergency facility if (i) the health maintenance organization or its designee or the member's primary care physician or its designee authorized, directed, or referred a member to use the hospital emergency facility; or (ii) the health maintenance organization fails to have a system for provision of

~~twenty-four-hour~~ *24-hour* access in accordance with subsection A above. For purposes of (i) above, a primary care physician may include a physician with whom the primary care physician has made arrangements for on-call backup coverage.

C. Each evidence of coverage provided by a health maintenance organization shall include a description of procedures to be followed by the member for emergency services, including: (i) the appropriate use of hospital emergency facilities; (ii) the appropriate use of any urgent care facilities with which the health maintenance organization may contract; (iii) the potential responsibility of the member for payment for nonemergency services rendered in a hospital emergency facility; and (iv) the member's covered benefits for emergency services, including an explanation of the prudent layperson standard included in the definition of emergency services in § 38.2-4300.

D. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.