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HOUSE BILL NO. 2411

House Amendments in [ ] — February 6, 2017

A BILL to amend and reenact §§ 30-347, 32.1-16, 32.1-137.2, 32.1-137.6, 32.1-137.7, 32.1-137.9, 32.1-137.13 through 32.1-137.16, 32.1-276.9:1, 32.1-352, 38.2-508, 38.2-508.1, 38.2-508.5, 38.2-3406.1, 38.2-3406.2, 38.2-3407.11, 38.2-3407.12, 38.2-3407.14, 38.2-3407.16, 38.2-3407.18, 38.2-3411.1, 38.2-3412.1, 38.2-3414, 38.2-3414.1, 38.2-3417, 38.2-3418.5, 38.2-3418.8, 38.2-3418.9, 38.2-3418.10, 38.2-3418.13 through 38.2-3418.17, 38.2-3430.3, 38.2-3430.6, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, 38.2-3436, 38.2-3500, 38.2-3501, 38.2-3503, 38.2-3520, 38.2-3521.1, 38.2-3522.1, 38.2-3523.4, 38.2-3525, 38.2-3540.2, 38.2-3541, 38.2-3551, 38.2-4109, 38.2-4214, 38.2-4217, 38.2-4229.1, 38.2-4306, 38.2-4310, 38.2-4312.3, 38.2-4319, 38.2-4509, 38.2-5900, and 58.1-2501 of the Code of Virginia; to amend the Code of Virginia by adding sections numbered 38.2-3416.1, 38.2-3433.1, 38.2-3541.3, 38.2-4216.2, and 38.2-5901.1 through 38.2-5901.4; and to repeal §§ 38.2-316.1 and 38.2-326, Articles 6 (§§ 38.2-3438 through 38.2-3454.1) and 7 (§§ 38.2-3455 through 38.2-3460) of Chapter 34 of Title 38.2, and Chapter 35.1 (§§ 38.2-3556 through 38.2-3571) of Title 38.2 of the Code of Virginia, relating to health insurance; reversion of provisions upon the repeal of the federal Patient Protection and Affordable Care Act; health benefit plans; individual and group coverage; market reforms; open enrollment programs; plan management functions; coordination with federal exchange; internal and external review processes; license tax.

Patron Prior to Engrossment — Delegate Byron

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 30-347, 32.1-16, 32.1-137.2, 32.1-137.6, 32.1-137.7, 32.1-137.9, 32.1-137.13 through 32.1-137.16, 32.1-276.9:1, 32.1-352, 38.2-508, 38.2-508.1, 38.2-508.5, 38.2-3406.1, 38.2-3406.2, 38.2-3407.11, 38.2-3407.12, 38.2-3407.14, 38.2-3407.16, 38.2-3407.18, 38.2-3411.1, 38.2-3412.1, 38.2-3414, 38.2-3414.1, 38.2-3417, 38.2-3418.5, 38.2-3418.8, 38.2-3418.9, 38.2-3418.10, 38.2-3418.13 through 38.2-3418.17, 38.2-3430.3, 38.2-3430.6, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3432.3, 38.2-3436, 38.2-3500, 38.2-3501, 38.2-3503, 38.2-3520, 38.2-3521.1, 38.2-3522.1, 38.2-3523.4, 38.2-3525, 38.2-3540.2, 38.2-3541, 38.2-3551, 38.2-4109, 38.2-4214, 38.2-4217, 38.2-4229.1, 38.2-4306, 38.2-4310, 38.2-4312.3, 38.2-4319, 38.2-4509, 38.2-5900, and 58.1-2501 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.2-3416.1, 38.2-3433.1, 38.2-3541.3, 38.2-4216.2, and 38.2-5901.1 through 38.2-5901.4 as follows:

§ 30-347. Medicaid Innovation and Reform Commission; membership; terms; compensation and expenses; definition.

A. The Medicaid Innovation and Reform Commission (the Commission) is established as a commission in the legislative branch of state government. The purpose of the Commission shall be to review, recommend and approve innovation and reform proposals affecting the implementation of Title XIX and Title XXI of the Social Security Act, including eligibility and financing for proposals set out in Item 307 of Chapter 806 of the 2013 Acts of Assembly. Specifically, the Commission shall review (i) the development of reform proposals; (ii) progress in obtaining federal approval for reforms such as benefit design, service delivery, payment reform, and quality and cost containment outcomes; and (iii) implementation of reform measures.

B. The Commission shall consist of 12 members as follows: the chair of the House Committee on Appropriations, or his designee, and four members of the House Committee on Appropriations appointed by the chair and the chair of the Senate Finance Committee, or his designee, and four members of the Senate Finance Committee appointed by the chair. In addition, the Secretaries of Finance and Health and Human Resources shall serve as ex officio, nonvoting members of the Commission.

C. Members shall serve terms coincident with their terms of office. Vacancies for unexpired terms shall be filled in the same manner as the original appointments. Members may be reappointed for successive terms.

D. ~~1.~~ The members of the Commission shall elect a chairman and vice chairman annually. A majority of the voting members of the Commission shall constitute a quorum. The meetings of the Commission shall be held at the call of the chairman or whenever the majority of the members so request. The Commission shall meet bimonthly beginning in June 2013, or as soon as possible thereafter.

~~2. An affirmative vote by three of the five members of the Commission from the House of Delegates and three of the five members of the Commission from the Senate shall be required to endorse any~~

~~reform proposal to amend the State Plan for Medical Assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act.~~

E. Legislative members of the Commission shall receive such compensation as provided in§ 30-19.12, and nonlegislative members shall receive such compensation as provided in § 2.2-2813.

§ 32.1-16. State Department of Health.

~~A.~~ There shall be a State Department of Health in the executive department responsible to the Secretary of Health and Human Resources. The Department shall be under the supervision and management of the State Health Commissioner. The Commissioner shall carry out his management and supervisory responsibilities in accordance with the policies, rules and regulations of the Board.

~~B. In addition to other duties imposed on the Department pursuant to this title, the Department shall assist in the plan management functions of the federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18041(c) in the Commonwealth, including providing assistance to the State Corporation Commission in its performance of plan management functions as set forth in § 38.2-326. The Department shall be compensated for expenses incurred in providing such services.~~

§ 32.1-137.2. Certification of quality assurance; application; issuance; denial; renewal.

A. Every managed care health insurance plan licensee shall request a certificate of quality assurance with reference to its managed care health insurance plans simultaneously with filing an initial application to the Bureau of Insurance for licensure. If already licensed by the Bureau of Insurance, every managed care health insurance plan licensee may file an application for quality assurance certification with the Department of Health by December 1, 1998, and shall file an application for quality assurance certification with the Department of Health by December 1, 1999, in order to obtain its certificate of quality assurance by July 1, 2000.

On or before July 1, 2000, the State Health Commissioner shall certify to the Bureau of Insurance that a managed care health insurance plan licensee has been issued a certificate of quality assurance by providing the Bureau of Insurance with a copy of each certificate at the time of issuance.

Application for a certificate of quality assurance shall be made on a form prescribed by the Board and shall be accompanied by a fee based upon a percentage, not to exceed one-tenth of one percent, of the proportion of direct gross premium income on business done in ~~this~~ *the* Commonwealth attributable to the operation of managed care health insurance plans in the preceding biennium, sufficient to cover reasonable costs for the administration of the quality assurance program. Such fee shall not exceed $10,000 per licensee. Whenever the account of the program shows expenses for the past biennium to be more than ten percent greater or lesser than the funds collected, the Board shall revise the fees levied by it for certification so that the fees are sufficient, but not excessive, to cover expenses; provided that such fees shall not exceed the limits set forth in this section. ~~Until July 1, 2014, the Department may utilize such certification funds as are needed in fulfilling its responsibilities pursuant to subsection B of § 32.1-16.~~

All applications, including those for renewal, shall require (i) a description of the geographic area to be served, with a map clearly delineating the boundaries of the service area or areas, (ii) a description of the complaint system required under § 32.1-137.6, (iii) a description of the procedures and programs established by the licensee to assure both availability and accessibility of adequate personnel and facilities and to assess the quality of health care services provided, and (iv) a list of the licensee's managed care health insurance plans.

B. Every managed care health insurance plan licensee certified under this article shall renew its certificate of quality assurance with the Commissioner biennially by July 1, subject to payment of the fee.

C. The Commissioner shall periodically examine or review each applicant for certificate of quality assurance or for renewal thereof.

No certificate of quality assurance may be issued or renewed unless a managed care health insurance plan licensee has filed a completed application and made payment of a fee pursuant to subsection A ~~of this section~~ and the Commissioner is satisfied, based upon his examination, that, to the extent appropriate for the type of managed care health insurance plan under examination, the managed care health insurance plan licensee has in place and complies with~~:~~ (i) a complaint system for reasonable and adequate procedures for the timely resolution of written complaints pursuant to § 32.1-137.6; (ii) a reasonable and adequate system for assessing the satisfaction of its covered persons; (iii) a system to provide for reasonable and adequate availability of and accessibility to health care services for its covered persons; (iv) reasonable and adequate policies and procedures to encourage the appropriate provision and use of preventive services for its covered persons; (v) reasonable and adequate standards and procedures for credentialing and recredentialing the providers with whom it contracts; (vi) reasonable and adequate procedures to inform its covered persons and providers of the managed care

health insurance plan licensee's policies and procedures; (vii) reasonable and adequate systems to assess, measure, and improve the health status of covered persons, including outcome measures, (viii) reasonable and adequate policies and procedures to ensure confidentiality of medical records and patient information to permit effective and confidential patient care and quality review; (ix) reasonable, timely and adequate requirements and standards pursuant to § 32.1-137.9; and (x) such other requirements as the Board may establish by regulation consistent with this article.

Upon the issuance or reissuance of a certificate, the Commissioner shall provide a copy of such certificate to the Bureau of Insurance.

D. Upon determining to deny a certificate, the Commissioner shall notify such applicant in writing stating the reasons for the denial of a certificate. A copy of such notification of denial shall be provided to the Bureau of Insurance. Appeals from a notification of denial shall be brought by a certificate applicant pursuant to the process set forth in § 32.1-137.5.

E. The State Corporation Commission shall give notice to the Commissioner of its intention to issue an order based upon a finding of insolvency, hazardous financial condition, or impairment of net worth or surplus to policyholders or an order suspending or revoking the license of a managed care health insurance plan licensee; and the Commissioner shall notify the Bureau of Insurance when he has reasonable cause to believe that a recommendation for the suspension or revocation of a certificate of quality assurance or the denial or nonrenewal of such a certificate may be made pursuant to this article. Such notifications shall be privileged and confidential and shall not be subject to subpoena.

F. No certificate of quality assurance issued pursuant to this article may be transferred or assigned without approval of the Commissioner.

§ 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 ~~determinations~~ *decisions* pursuant to § 32.1-137.15.

B. The Commissioner, in cooperation with the Bureau of Insurance, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this article shall be assessed by the State Health Commissioner under this article. Compliance by the health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of Title 38.2, shall be assessed by the Bureau of Insurance.

C. As part of the renewal of a certificate, each managed care health insurance plan licensee shall submit to the Commissioner and to the Office of the Managed Care Ombudsman an annual complaint report in a form agreed and prescribed by the Board and the Bureau of Insurance. The complaint report shall include, but shall not be limited to (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the managed care health insurance plan's health care providers.

The Department of 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 ~~determination~~ *decision*" means a *utilization review* determination by the ~~managed care health insurance plan or its designee~~ utilization review entity that~~, based upon information provided, a request for a benefit upon application of any utilization review technique does not meet the managed care health insurance plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit~~ *a health 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*. 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 ~~determination~~ *decision* shall be made within 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 ~~determination~~ *decision*" means ~~an adverse~~ *a utilization review* determination ~~involving a covered benefit that has been upheld by a managed care health insurance plan, or its designee utilization review entity, at the completion of the managed care health insurance plan's internal appeal process~~ *involving a covered benefit that has been upheld by a managed care health insurance plan, or its designee utilization review entity, at the completion of the managed care health insurance plan's internal appeal process*.

"Medical director" means a physician licensed to practice medicine in the Commonwealth of Virginia who is an employee of a utilization review entity 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.

"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, 38.2-118, 38.2-119, 38.2-124, 38.2-125, 38.2-126, 38.2-130, 38.2-131, 38.2-132, and 38.2-134.

"Utilization review entity" 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 ~~determination~~ *decision* shall be made only in accordance with § 32.1-137.13.

C. Each entity shall have a process for reconsideration of an adverse ~~determination~~ *decision* 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 ~~determination~~ *decision* rendered under § 32.1-137.13, as required by § 32.1-137.14, and the process for ~~internal~~ appeal from ~~an~~ *a final* adverse ~~determination~~ *decision* 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 decision.

A. The treating provider shall be notified in writing of any adverse ~~determination~~ *decision* within two working days of the determination; however, the treating provider shall be notified orally by telephone within 24 hours of any adverse ~~determination~~ *decision* 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 ~~determination~~ *decision* pursuant to § 32.1-137.14, including the contact name, address, and telephone number of the person responsible for making the adverse ~~determination~~ *decision*, and (ii) seek an appeal of the adverse ~~determination~~ *decision* 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 ~~determination~~ *decision* unless it has made a good faith attempt to obtain information from the provider. At any time before the entity renders its ~~determination~~ *decision*, 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 ~~determination~~ *decision* 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 decision.

A. A treating provider may request reconsideration of an adverse ~~determination~~ *decision* pursuant to this section or may appeal an adverse ~~determination~~ *decision* pursuant to § 32.1-137.15. Any reconsideration of an adverse ~~determination~~ *decision* shall only be requested by the treating provider on behalf of the covered person. A ~~determination~~ *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 ~~determination~~ *decision* and in writing following the determination of the reconsideration of the adverse ~~determination~~ *decision*, in accordance with

§ 32.1-137.9, including the criteria used and the clinical reason for the adverse ~~determination~~ *decision* 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 ~~determination~~ *decision* 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 ~~determination~~ *decision* 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 ~~determination~~ *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. Adverse decision; appeal.

A. Each entity shall establish an ~~internal~~ appeals process, including a process for ~~urgent~~ ~~care~~ *expedited* appeals, to consider any *final* adverse ~~determination~~ *decision* that is appealed by a covered person, his representative, or his provider ~~in~~ ~~accordance~~ ~~with~~ ~~the~~ ~~provisions~~ ~~of~~ ~~§ 38.2-3558~~. *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 shall be in writing and shall state the criteria used and the clinical reason for the decision. If the appeal is denied, such notification shall include a clear and understandable description of the covered person's right to appeal final adverse decisions to the Bureau of Insurance in accordance with Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2, the procedures for making such an appeal, and the binding nature and effect of such an appeal, including all forms prescribed by the Bureau of Insurance pursuant to § 38.2-5901.1. Such notification shall also include the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman. Further, such notification shall advise any such covered person that, except in the instance of fraud, any such appeal herein may preclude such person's exercise of any other right or remedy relating to such adverse decision. An expedited appeals process of no more than 24 hours shall be established and conducted by telephone to consider any final adverse decision that relates to a prescription to alleviate cancer pain.*

B. Any case under appeal shall be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal shall be a peer of the treating health care provider, shall be board certified 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 on appeal shall (i) not have participated in the adverse decision or any prior reconsideration thereof, (ii) not be employed by or a director of the utilization review entity, and (iii) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

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

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

E. When an adverse decision or adverse reconsideration is made and the treating health care provider believes that the decision warrants an immediate appeal, the treating health care provider shall have the opportunity to appeal the adverse decision or adverse reconsideration by telephone on an expedited basis. The treating health care provider shall have the opportunity to appeal immediately, by telephone, on an expedited basis, an adverse decision or adverse reconsideration relating to a prescription to alleviate cancer pain.

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

The utilization review entity shall decide the expedited appeal no later than one business day after

receipt by the entity of all necessary information.

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

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

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

G. No entity performing utilization review pursuant to this article or Article 2.1 (§ 32.1-138.6 et seq.) 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.

§ 32.1-137.16. Records.

Every entity subject to Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 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 ~~determinations~~ *decisions*; records of complaints received, including the manner in which the complaints were resolved; the number and type of adverse ~~determinations~~ *decisions* and reconsiderations; the number and outcome of final adverse ~~determinations~~ *decisions* 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.) shall be maintained from the date of the entity's last examination and for no less than 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 ~~six~~ *five* years, and all such records shall be subject to examination by the Commissioner or his designee.

§ 32.1-276.9:1. Health information needs related to reform; work group.

A. The Commissioner shall direct the nonprofit organization to establish a work group to study continuing health information needs and to develop recommendations for design, development, and operation of systems and strategies to meet those needs. The work group shall include representatives of the Department of Health, the Department of Medical Assistance Services, the Department of Health Professions, the State Corporation Commission's Bureau of Insurance, the Virginia Health Reform Initiative, the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, health care providers, and other stakeholders and shall:

1. Identify various health information needs related to implementation of health care reform initiatives, including those associated with development and operation of an all-payer claims database, the Virginia Health Information Exchange~~, the Virginia Health Benefit Exchange~~, and any other health reform initiatives. In doing so, the work group shall identify the clinical and paid claims information required and the purposes for which such information will be used; and

2. Identify opportunities for maximizing efficiency and effectiveness of health information systems, reducing duplication of effort related to collection of health information, and minimizing costs and risks associated with collection and use of health information.

B. The Commissioner shall report on activities, findings, and recommendations of the work group annually to the Governor and the General Assembly no later than December 1 of each year, beginning in 2014.

§ 32.1-352. Virginia Family Access to Medical Insurance Security Plan Trust Fund.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Family Access to Medical Insurance Security Plan Trust Fund, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. The Fund shall consist of the premium differential, any and all employer contributions which may be solicited or received by the Department of Medical Assistance Services, grants, donations, gifts, and bequests, or any and all moneys designated for the Fund, from any source, public or private. As used in this section, "premium differential" means an amount equal to the difference between (i) 0.75 percent of the direct gross subscriber fee income derived

from eligible contracts and (ii) the amount of license tax revenue generated pursuant to former subdivision A 4 of § 58.1-2501 with respect to eligible contracts. As used in this section, "eligible contract" means any subscription contract for any kind of plan classified and defined in § 38.2-4201 or 38.2-4501 issued other than to (i) an individual or (ii) a primary small group employer if income from the contract is subject to license tax at the rate of 2.25 percent pursuant to ~~former~~ subsection D of § 38.2-4229.1. The Department of Taxation shall annually, on or before June 30, calculate the premium differential for the immediately preceding taxable year and notify the Comptroller of the Commonwealth to transfer such amount to the Virginia Family Access to Medical Insurance Security Plan Trust Fund as established on the books of the Comptroller.

B. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely to support the Virginia Family Access to Medical Insurance Security Plan in accordance with the requirements of Title XXI of the Social Security Act, as amended, the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP), as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33), and any conditions set forth in the appropriation act.

C. The Director of the Department of Medical Assistance Services shall report annually on December 1 to the Governor, the General Assembly, and the Joint Commission on Health Care on the status of the Fund, the number of children served by this program, the costs of such services, and any issues related to the Virginia Family Access to Medical Insurance Security Plan that may need to be addressed.

§ 38.2-508. Unfair discrimination.

No person shall:

1. Unfairly discriminate or permit any unfair discrimination between individuals of the same class and equal expectation of life (i) in the rates charged for any life insurance or annuity contract, ~~or~~ (ii) in the dividends or other benefits payable on the contract, or (iii) in any other of the terms and conditions of the contract;

2. Unfairly discriminate or permit any unfair discrimination between individuals of the same class and of essentially the same hazard (i) in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance~~,~~*;* (ii) in the benefits payable under such policy or contract~~,~~*;* (iii) in any of the terms or conditions of such policy or contract~~,~~*;* or (iv) in any other manner;

3. Refuse to insure, refuse to continue to insure, or limit the amount, extent, or kind of insurance coverage available to an individual, or charge an individual a different rate for the same coverage solely because of blindness, or partial blindness, or mental or physical impairments, unless the refusal, limitation, or rate differential is based on sound actuarial principles. This ~~paragraph~~ *subdivision* shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

4. Unfairly discriminate or permit any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage solely because of the geographic location of the individual or risk, unless:

a. The refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

b. The refusal, cancellation, or limitation is required by law or regulatory mandate;

5. Make or permit any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained in a residential property risk, solely because of the age of the residential property, unless:

a. The refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

b. The refusal, cancellation, or limitation is required by law or regulatory mandate;

6. Refuse to issue or renew any individual accident and sickness insurance policy or contract for coverage over and above any lifetime benefit of a group accident and sickness policy or contract solely because an individual is insured under a group accident and sickness insurance policy or contract, provided that medical expenses covered by both individual and group coverage shall be paid first by the group policy or contract to the extent of the group coverage. *This subsection shall not apply to individual policies or contracts issued or renewed pursuant to § 38.2-4216.2*; or

7. Consider the status of a victim of domestic violence as a criterion in any decision with regard to insurance underwriting, pricing, renewal, scope of coverage, or payment of claims on any and all insurance defined in § 38.2-100 and further classified in Article 2 (§ 38.2-101 et seq.) of Chapter 1 ~~of this title~~, other than (i) legal services plans as provided for in Chapter 44 (§ 38.2-4400 et seq.) ~~of this title~~ and (ii) the insurance classified in §§ 38.2-110 through 38.2-133. The term "domestic violence" means the occurrence of one or more of the following acts by a current or former family member, household member as defined in § 16.1-228, person against whom the victim obtained a protective order,

or caretaker:

a. Attempting to cause or causing or threatening another person physical harm, severe emotional distress, psychological trauma, rape, or sexual assault;

b. Engaging in a course of conduct or repeatedly committing acts toward another person, including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

c. Subjecting another person to false imprisonment; or

d. Attempting to cause or causing damage to property so as to intimidate or attempt to control the behavior of another person.

Nothing in this subsection shall prohibit an insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under an insurance policy even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know resulted from domestic violence, to the extent otherwise permitted under this section and other applicable law.

§ 38.2-508.1. Unfair discrimination; members of the armed forces.

A. No person shall refuse to issue or refuse to continue a life insurance policy on the life of any member of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard due to (i) their status as a member of any such military organization or (ii) their duty assignment while a member of any such military organization.

B. In circumstances where an individual's or family member's coverage under a group life or group health insurance policy or contract was terminated due to such individual's status as a member of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard, no person shall refuse to reinstate such coverage, regardless of continuation, renewal, reissue or replacement of the group insurance policy, upon the occurrence of the individual's return to eligibility status under the policy or contract. Such reinstated coverage shall not contain any new preexisting condition or other exclusions or limitations except that the remainder of a preexisting condition requirement that was not satisfied prior to termination of the individual's coverage resulting from such military status may be applied once the individual returns and coverage under the group policy is reinstated.

~~C. 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.~~

§ 38.2-508.5. 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.

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 ~~an average of~~ at least ~~one~~ *two* but not more than 50 eligible individuals on business days during the preceding calendar year and who employs at least ~~one~~ *two* eligible ~~individual~~ *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 13 or older covered thereunder direct access, as provided in subsection B, to the health care services of a participating obstetrician-gynecologist (a) authorized to provide services under such policy, contract or plan and (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.~~

§ 38.2-3407.12. Patient optional point-of-service benefit.

A. As used in this section:

"Affiliate" shall have the meaning set forth in § 38.2-1322.

"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;

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

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

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

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

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

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

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

"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.

"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.

"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.

"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (TRICARE) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), TRICARE supplement, Medicare supplement, or workers' compensation coverages; ~~or~~ (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded*; or (v) the essential and standard health benefit plans developed pursuant to subsection C of § 38.2-3431*.

"Group specific administrative cost" means the direct administrative cost incurred by a carrier related to the offer of the point-of-service benefit to a particular group contract holder.

"Health care plan" shall have the meaning set forth in § 38.2-4300.

"Person" means any individual, corporation, trust, association, partnership, limited liability company, organization or other entity.

"Point-of-service benefit" means a health maintenance organization's delivery system or covered benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with the health maintenance organization, which permit an enrollee (and eligible dependents) to receive covered items and services outside of the provider panel, including optometrists and clinical psychologists, of the health maintenance organization under the terms and conditions of the group contract holder's group health benefit plan with the health maintenance organization or with another carrier arranged by or under contract with the health maintenance organization and which otherwise complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee (and eligible dependents) to receive the full range of covered items and services outside of a provider panel, including optometrists and clinical psychologists, and which are otherwise in compliance with applicable law and this section shall constitute a point-of-service benefit.

"Preferred provider organization plan" means a health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209.

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

"Provider panel" means the participating providers or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health maintenance organization or other carrier.

B. To the maximum extent permitted by applicable law, every health care plan offered or proposed to be offered in ~~the large group market in~~ the Commonwealth by a health maintenance organization licensed under this title to a group contract holder shall provide or include, or the health maintenance organization shall arrange for or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered in conjunction with the health maintenance organization's health care plan as an additional benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every health maintenance organization shall, at no additional cost to the group contract holder, make available or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance acceptable to the Commission which accurately and completely explains to the group contract holder and prospective enrollee the point-of-service benefit and permits each enrollee to make his or her election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the carrier in any reasonable manner.

C. To the extent permitted under applicable law, a health maintenance organization providing or arranging, or contracting with another carrier to provide, the point-of-service benefit under this section and a carrier providing the point-of-service benefit required under this section under arrangement or contract with a health maintenance organization:

1. May not impose, or permit to be imposed, a minimum enrollee participation level on the point-of-service benefit alone;

2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or 38.2-4221 for items or services provided under the point-of-service benefit required under this section solely on the basis of the license or certification of the provider to provide such items or services if the carrier otherwise covers the items or services provided and the provision of the items or services is within the provider's lawful scope of practice or authority; and

3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group prior to any enrollee electing to accept or reject the point-of-service benefit.

D. The premium imposed by a carrier with respect to enrollees who select the point-of-service benefit may be different from that imposed by the health maintenance organization with respect to enrollees who do not select the point-of-service benefit. Unless a group contract holder determines otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of any premium over the amount of the premium applicable to an enrollee who selects the coverage offered by the health maintenance organization without the point-of-service benefit and for any identifiable

group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization; provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) thirty percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service benefit any condition or penalty designed to discourage the enrollee's selection or use of the point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

H. Except as expressly otherwise permitted in this section or as otherwise required under applicable law, the scope of the health care items and services which are covered under the point-of-service benefit

required under this section shall at least include the same health care items and services which would be covered if provided under the health maintenance organization's health care plan, including without limitation any items or services covered under a rider or endorsement to the applicable health care plan. Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing materials utilized with respect to such group health benefit plans that the scope of the benefits provided under the point-of-service option are at least as great as those provided through the HMO's health care plan for that group. Filings of point-of-service benefits submitted to the Commission shall be accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the point-of-service benefits includes at a minimum the same health care items and services as are provided under the HMO's group health care plan for that group.

I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the health maintenance organization's group health benefit plan which does not contain the point-of-service benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is offered in a manner which separates or otherwise differentiates it from the group health benefit plan which does not contain the point-of-service benefit.

J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit under this section with respect to any group health benefit plan offered to a group contract holder if the health maintenance organization determines in good faith that the group contract holder will be concurrently offering another group health benefit plan or a self-insured or self-funded health benefit plan which allows the enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization's panel.

K. This section shall apply only to group health benefit plans issued in the Commonwealth in the commercial ~~large~~ group market by carriers regulated by this title and shall not apply to (i) health care plans, contracts or policies issued in the individual ~~or small~~ group market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (TRICARE) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), TRICARE supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; or (v) ~~a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the federal Patient Protection and Affordable Care Act (P.L. 111-148)~~ *the essential and standard health benefit plans developed pursuant to subsection C of § 38.2-3431*.

L. Nothing in this section shall operate to limit any rights or obligations arising under § 38.2-3407, 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312, or 38.2-4312.1.

§ 38.2-3407.14. Notice of premium or deductible increases.

A. Each (i) insurer issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, shall provide in conjunction with the proposed renewal of coverage under any such policies, contracts, or plans, prior written notice of intent to increase by more than 35 percent the annual premium charged for coverage thereunder.

B. ~~Effective with policy, contract, or plan year renewals beginning on or after January 1, 2015, each health carrier providing individual health insurance coverage shall provide in conjunction with the proposed renewal of individual health insurance coverage prior written notice of intent to increase the annual premium charge for coverage or any deductible required thereunder. As used in this section, "deductible" means the annual dollar amount of covered items or services that the insured, subscriber, or enrollee is obligated to pay before benefits are payable under the health benefit plan.~~

~~C.~~ Notice required by this section shall be provided in writing at least 60 days prior to the proposed renewal of coverage under any such policy, contract, or plan ~~described in subsection A and effective with policy, contract, or plan year renewals beginning on or after January 1, 2015, at least 75 days prior to the proposed renewal of individual health insurance coverage described in subsection B. In either case, notice shall be provided~~ to the policyholder, contract holder, or subscriber, ~~or to the designated consultant or other agent of the group policyholder, contract holder, or subscriber if requested in writing by the group policyholder, contract holder, or subscriber,~~ as appropriate.

~~D. The time frames specified in subsection C for the provision of notices may be adjusted by the~~

~~Commission's Bureau of Insurance to account for delays in product or rate approval by the Bureau of Insurance that result from filing requirements established by the United States Department of Health and Human Services.~~

§ 38.2-3407.16. Requirements for obstetrical care.

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 services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical illness generally.

B. 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, on and after the effective date of this section. The provisions of this section shall not apply to short-term travel, accident only, ~~or~~ limited or specified disease, *or individual conversion* policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3407.18. Requirements for orally administered cancer chemotherapy drugs.

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 cancer chemotherapy drugs administered orally and intravenously or by injection shall provide that the criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

B. 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, on and after the effective date of this section. The provisions of this section shall not apply to short-term travel, accident only, ~~or~~ limited or specified disease, *or individual conversion* policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

C. This section shall apply to health coverage offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, local officers, teachers and retirees pursuant to § 2.2-1204. In administering such coverage, the criteria for establishing the level of copayments or coinsurance for orally administered cancer treatment drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

§ 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, 12 months, 15 months, 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.~~

§ 38.2-3412.1. Coverage for mental health and substance use disorders.

A. As used in this section:

"Adult" means any person who is 19 years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of 19 years.

"Inpatient treatment" means mental health or substance abuse services delivered on a 24-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured 24-hour per day, state-approved program of inpatient substance abuse services.

"Medication management visit" means a visit no more than 20 minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental health services" or "mental health benefits" means benefits with respect to items or services for mental health conditions as defined under the terms of the health benefit plan. Any condition defined by the health benefit plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Substance abuse services" or "substance use disorder benefits" means benefits with respect to items or services for substance use disorders as defined under the terms of the health benefit plan. Any disorder defined by the health benefit plan as being or as not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current medical practice.

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed

professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope of practice set forth in § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed to provide such treatment.

B. ~~Except as provided in subsections C and D, group~~ *Group* and individual health insurance coverage, as defined in § 38.2-3431, shall provide mental health and substance use disorder benefits. Such benefits shall be in parity with the medical and surgical benefits contained in the coverage in accordance with the Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, even where those requirements would not otherwise apply directly.

~~C. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall either continue to provide benefits in accordance with subsection B or continue to provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:~~

~~1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20 days per policy or contract year.~~

~~2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 25 days per policy or contract year.~~

~~3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein that provides inpatient benefits in excess of 20 days per policy or contract year for adults or 25 days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.~~

~~4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.~~

~~5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.~~

~~D. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall also either continue to provide benefits in accordance with subsection B or continue to provide coverage for outpatient mental health and substance abuse services as follows:~~

~~1. A minimum of 20 visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.~~

~~2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.~~

~~3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.~~

~~4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.~~

~~5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.~~

~~E. The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, renewed, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment made.~~

~~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.~~

§ 38.2-3414. Optional coverage for obstetrical services.

A. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue group hospital, group medical or group major medical subscription contracts shall provide coverage for obstetrical services as an option available to

the group policyholder or the contract holder in the case of benefits based upon treatment as an inpatient in a general hospital. The reimbursement for obstetrical services by a physician shall be based on the charges for the services determined according to the same formula by which the charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

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

§ 38.2-3414.1. Obstetrical benefits; coverage for postpartum services.

A. Each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care services that provides benefits for obstetrical services shall provide coverage for postpartum services as provided in this section.

B. Such coverage shall include benefits for inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 1996, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

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

§ 38.2-3416.1. Conversion on termination of eligibility; insurer required to offer conversion policy or group coverage.

A. Before an insurer that delivers or issues for delivery in the Commonwealth, or who renews, reissues, or extends if already issued, any group hospital, medical and surgical, or group major medical policy, the insurer shall be required to be able to offer without evidence of insurability to residents of the Commonwealth who are covered under the policy, whose eligibility may terminate under the policy, and who may elect Option 1 under § 38.2-3541 a nongroup policy of accident and sickness insurance, either individual or family, whichever is appropriate, pursuant to the provisions of § 38.2-3541 unless such termination is due to termination of the group policy under circumstances in which the insured person is insurable under other replacement group coverage or health care plan without waiting periods or preexisting conditions under the replacement coverage or plan.

B. Any insurer who has in effect prior to January 1, 1985, any group policy described in subsection A may be exempted from the provisions of subsection A. However, for persons affected by the termination of eligibility, the insurer shall be required to continue coverage under the existing group policy, without evidence of insurability and at the insurer's current rate applicable to the group policy, for as long as the affected persons elect or as long as the insurer is not required to offer an acceptable conversion policy.

§ 38.2-3417. Deductibles and coinsurance options required.

A. An insurer issuing accident and sickness insurance or a corporation issuing subscription contracts on an expense incurred basis shall make available in offering such coverage or contract to the potential insured or contract holder one or more of the following options under which the individual insured or group certificate holder pays for:

1. The first $100 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period;

2. Twenty percent of the first $1,000 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period;

3. The first $100 and 20 percent of the next $1,000 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period; or

4. Any other option containing a greater deductible, coinsurance, or cost-sharing provision. However, the option shall not be inconsistent with standards established with respect to deductibles, coinsurance, or cost-sharing pursuant to § 38.2-3519.

B. As used in this section, "make available" means that the insurer or corporation shall disseminate

information concerning the option or options and make a policy or contract containing the option or options available to potential insureds or contract holders at the same time and in the same manner as the insurer or corporation disseminates information concerning other policies or contracts and coverage options and makes other policies or contracts and coverage options available.

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

~~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.~~

§ 38.2-3418.5. 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.~~

§ 38.2-3418.8. Coverage for clinical trials for treatment studies on cancer.

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 patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials, under any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.

B. The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

C. For purposes of this section:

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

"FDA" means the Federal Food and Drug Administration.

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

a policyholder, subscriber, insured or certificate holder.

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

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

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

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

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

1. The National Cancer Institute;

2. An NCI cooperative group or an NCI center;

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

4. The federal Department of Veterans Affairs; or

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

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

G. Coverage under this section shall apply only if:

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

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

3. The member and the physician or health care provider who provides services to the member under the insurance policy, subscription contract or health care plan conclude that the member's participation in the clinical trial would be appropriate, pursuant to procedures established by the insurer, corporation or health maintenance organization and as disclosed in the policy and evidence of coverage.

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

~~I. 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.~~

§ 38.2-3418.9. Minimum hospital stay for hysterectomy.

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

B. Such coverage shall include benefits for a minimum stay in the hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. Nothing in this subsection shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate.

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

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

§ 38.2-3418.10. Coverage for diabetes.

A. Each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care

plan for health care services shall provide coverage for diabetes as provided in this section.

B. Such coverage shall include benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. As used herein, the terms "equipment" and "supplies" shall not be considered durable medical equipment.

C. To qualify for coverage under this section, diabetes in-person outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional. A managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of this title, may require such health care professional to be a member of the plan's provider network; provided that such network includes sufficient health care professionals who are qualified by specific education, experience, and credentials to provide the covered benefits described in this section.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, nor shall any insurer, corporation or health maintenance organization impose any policy-year or calendar-year dollar or durational benefit limitations or maximums for benefits or services provided under this section.

E. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 2000, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

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

§ 38.2-3418.13. Coverage for the treatment of morbid obesity.

A. Notwithstanding the provisions of § 38.2-3419, ~~in the large group market,~~ 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 offer and make available coverage under any such policy, contract or plan for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

B. The reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Standards and criteria, including those related to diet, used by insurers to approve or restrict access to surgery for morbid obesity shall be based upon current clinical guidelines recognized by the National Institutes of Health.

C. For purposes of this section, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration~~; health care plans, contracts, or policies issued in the individual or small group market; or a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the federal Patient Protection and Affordable Care Act (P.L. 111-148)~~.

§ 38.2-3418.14. Coverage for lymphedema.

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 lymphedema as provided in this section.

B. Coverage under this section shall include benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

C. A managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of this title, may require such health care professional to be a member of the plan's provider network, provided that such network includes sufficient health care professionals who are qualified by specific education, experience, and credentials to provide the covered benefits described in this section.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee, policy year or calendar year, or durational benefit limitation or maximum for benefits or services that is not equally imposed upon all individuals in the same benefit category.

E. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended in this Commonwealth on and after January 1, 2004, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

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

§ 38.2-3418.15. Coverage for prosthetic devices and components.

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 offer and make available coverage for medically necessary prosthetic devices, their repair, fitting, replacement, and components, as follows:

1. As used in this section:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

2. Prosthetic device coverage does not include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not include prosthetic devices designed primarily for an athletic purpose.

3. An insurer shall not impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. The coverage may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

4. An insurer shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

5. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any coinsurance in excess of 30 percent of the carrier's allowable charge for such prosthetic device or services when such device or service is provided by an in-network provider.

6. An insurer, corporation, or health maintenance organization may require preauthorization to determine medical necessity and the eligibility of benefits for prosthetic devices and components, in the same manner that prior authorization is required for any other covered benefit.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2010, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

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

§ 38.2-3418.16. Coverage for telemedicine 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 the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section, "telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

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

§ 38.2-3418.17. Coverage for autism spectrum disorder.

A. Notwithstanding the provisions of § 38.2-3419 and any other provision of law, each insurer proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall, as provided in this section, provide coverage for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder, in individuals (i) from January 1, 2012, until January 1, 2016, from age two years through age six years and (ii) from and after January 1, 2016, from age two years through age 10 years, subject to the annual maximum benefit limitation set forth in subsection K and to provisions of subsection G. If an individual who is being treated for autism spectrum disorder becomes older than the applicable maximum age set forth in the preceding sentence and continues to need treatment, this section does not preclude coverage of treatment and services. In addition to the requirements imposed on health insurance issuers by § 38.2-3436, an insurer shall not terminate coverage or refuse to deliver, issue, amend, adjust, or renew coverage of an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder.

B. For purposes of this section:

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder — Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral health treatment" means professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

"Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

"Medically necessary" means based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

"Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

"Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or clinical social workers.

"Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavior analysis when provided or supervised by a board certified behavior analyst who shall be licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

"Treatment plan" means a plan for the treatment of autism spectrum disorder developed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

C. Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, an insurer, corporation, or health maintenance organization shall have the right to request a review of that treatment, including an independent review, not more than once every 12 months unless the insurer, corporation, or health maintenance organization and the individual's licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review, including an independent review, shall be covered under the policy, contract, or plan.

D. Coverage under this section will not be subject to any visit limits, and shall be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

E. Nothing shall preclude the undertaking of usual and customary procedures, including prior authorization, to determine the appropriateness of, and medical necessity for, treatment of autism spectrum disorder under this section, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan.

F. The provisions of this section shall not apply to (i) short-term travel, accident only, limited, or specified disease policies; (ii) short-term nonrenewable policies of not more than six months' duration; (iii) policies, contracts, or plans issued in the individual market or small group markets; or (iv) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

G. The requirements of this section requiring that coverage be provided with regard to individuals from age two years through age six years shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2012, but prior to January 1, 2016, and the requirements of this section requiring that coverage be provided with regard to individuals from age two years through age 10 years shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or

after January 1, 2016, and to all such policies, contracts, or plans to which a term is changed or any premium adjustment is made on or after such date.

H. Any coverage required pursuant to this section shall be in addition to the coverage required by § 38.2-3418.5 and other provisions of law. This section shall not be construed as diminishing any coverage required by § 38.2-3412.1. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

I. Pursuant to the provisions of § 2.2-2818.2, this section shall apply to health coverage offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, teachers, and retirees pursuant to § 2.2-1204.

J. Notwithstanding any provision of this section to the contrary

1. An insurer, corporation, or health maintenance organization, or a governmental entity providing coverage for such treatment pursuant to subsection I, is exempt from providing coverage for behavioral health treatment required under this section and not covered by the insurer, corporation, health maintenance organization, or governmental entity providing coverage for such treatment pursuant to subsection I as of December 31, 2011, if:

a. An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a member of the American Academy of Actuaries and meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making, certifies in writing to the Commissioner of Insurance that:

(1) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization, or such governmental entity, for the most recent experience period of at least one year's duration, the costs associated with coverage of behavioral health treatment required under this section, and not covered as of December 31, 2011, exceeded one percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

(2) Those costs solely would lead to an increase in average premiums charged of more than one percent for all insurance policies, subscription contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, or health maintenance organization, or such governmental entity, employs; and

b. The Commissioner approves the certification of the actuary;

2. An exemption allowed under subdivision 1 shall apply for a one-year coverage period following inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization, or such governmental entity, shall again provide coverage for behavioral health treatment required under this section;

3. An insurer, corporation, or health maintenance organization, or such governmental entity, may claim an exemption for a subsequent year, but only if the conditions specified in subdivision 1 again are met; and

4. Notwithstanding the exemption allowed under subdivision 1, an insurer, corporation, or health maintenance organization, or such a governmental entity, may elect to continue to provide coverage for behavioral health treatment required under this section.

K. Coverage for applied behavior analysis under this section will be subject to an annual maximum benefit of $35,000, unless the insurer, corporation, or health maintenance organization elects to provide coverage in a greater amount.

~~L. As of January 1, 2014, to the extent that this section requires benefits that exceed the essential health benefits specified under § 1302(b) of the federal Patient Protection and Affordable Care Act (H.R. 3590), as amended (the ACA), the specific benefits that exceed the specified essential health benefits shall not be required of a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the ACA. Nothing in this subsection shall nullify application of this section to plans offered outside such an exchange.~~

§ 38.2-3430.3. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

A. Guaranteed availability.

1. All eligible individuals shall be provided a choice of all individual health insurance coverage currently being offered by a health insurance issuer and the chosen coverage shall be issued.

2. The coverage provided as required in subdivision A 1 shall not impose any preexisting condition exclusion or affiliation period with respect to the coverage.

B. Health insurance issuers are prohibited from imposing any limitations or exclusions based upon named conditions that apply to eligible individuals.

C. Health insurance issuers shall include on all applications for health insurance coverage questions

which will enable the health insurance issuer to determine if an applicant is applying for coverage as an eligible individual as defined in § 38.2-3430.2. This requirement shall not apply to applications used in connection with managed health care plans administering and providing care to Medicare beneficiaries in exchange for preestablished compensation from Medicare, as permitted under applicable state and federal guidelines.

~~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.~~

§ 38.2-3430.6. Market requirements.

A. The provisions of § 38.2-3430.3 shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

B. A health insurance issuer offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

§ 38.2-3431. Application of article; definitions.

A. This article applies to group health plans and to health insurance issuers offering group health insurance coverage, and individual policies offered to employees of small employers.

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 or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in this Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium;

3. The employer has permitted payroll deduction for the covered individual and any portion of the premium is paid by the employer, provided that the health insurance issuer providing individual coverage under such circumstances shall be registered as a health insurance issuer in the small group market under this article, and shall have offered small employer group insurance to the employer in the manner required under this article; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of § 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a health insurance issuer is in compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer in establishing premium rates for applicable insurance coverage.

"Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

1. Such period shall begin on the enrollment date.

2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in this Commonwealth, an association which:

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage if any under such COBRA continuation provision, and the waiting period if any and affiliation period if applicable imposed with respect to the individual for any coverage under such plan.

"Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (33)).

"COBRA continuation provision" means any of the following:

1. Section 4980B of the Internal Revenue Code of 1986(26 U.S.C. § 4980B), other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

3. Title XXII of P.L. 104-191.

"Community rate" means the average rate charged for the same or similar coverage to all small employer groups with the same area, age, and gender characteristics. This rate shall be based on the health insurance issuer's combined claims experience for all groups within its small employer market.

"Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);

4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

9. A public health plan (as defined in federal regulations);

10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)); or

11. Individual health insurance coverage.

Such term does not include coverage consisting solely of coverage of excepted benefits.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. ~~At the employer's sole discretion, the eligibility criterion may be broadened to include part-time employees.~~

"Eligible individual" means such an individual in relation to the employer as shall be determined:

1. In accordance with the terms of such plan;

2. As provided by the health insurance issuer under rules of the health insurance issuer which are uniformly applicable to employers in the group market; and

3. In accordance with all applicable law of this Commonwealth governing such issuer and such market.

"Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

"Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or more employees.

"Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection C.

"Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

1. Benefits not subject to requirements of this article:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Benefits not subject to requirements of this article if offered separately:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

c. Such other similar, limited benefits as are specified in regulations.

3. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

4. Benefits not subject to requirements of this article if offered as separate insurance policy:

a. Medicare supplemental health insurance (as defined under section 1882 (g)(1) of the Social Security Act (42 U.S.C. § 1395ss (g)(1));

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

c. Similar supplemental coverage provided to coverage under a group health plan.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

"Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

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

"Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in this Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within the meaning of section 514 (b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b)(2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

2. An organization recognized under the laws of this Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of this Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability (including conditions arising out of acts of domestic violence); or
8. Disability.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. Individual health insurance coverage does not include short-term limited duration coverage.

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

"Large employer" means, in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least ~~one employee~~ *two employees* on the first day of the plan year.

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer *or through a health insurance issuer*.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

1. The first period in which the individual is eligible to enroll under the plan; or
2. A special enrollment period as required pursuant to subsections J through M of § 38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, 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 medical care referred to in subdivision 1; and
3. Insurance covering medical care referred to in subdivisions 1 and 2.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the health insurance issuer.

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (7)).

"Placed for adoption," or "placement" or "being placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"Plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16)(B)).

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from a health insurance issuer, including fees and other contributions associated with the health benefit plan.

"Rating period" means the 12-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

"Service area" means a broad geographic area of the Commonwealth in which a health insurance issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least ~~one~~ *two* but not more than 50 employees on business days during the preceding calendar year and who employs at least ~~one employee~~ *two employees* on the first day of the plan year.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer *or through a health insurance issuer*.

"State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means, with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. If an employee or dependent enrolls during a special enrollment period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such enrollment is not a waiting period.

C. 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~~ *Commission shall adopt regulations establishing the essential and standard plans for sale in the small employer market. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the Acts of Assembly of 1992. Every health insurance issuer shall, as a condition of transacting business in Virginia with small employers, offer to small employers the essential and standard plans, subject to the provisions of § 38.2-3432.2. However, any regulation adopted by the Commission shall contain a provision requiring all health insurance issuers to offer an option permitting a small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 (§ 38.2-4500 et seq.). All health insurance issuers shall issue the plans to every small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and shall satisfy the following provisions:*

1. Such plan may include cost containment and cost sharing features such as, but not limited to, utilization review of health care services, including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians, and other health care providers, subject to the limitations set forth in §§ 38.2-3407 and 38.2-4209 and Chapter 43 (§ 38.2-4300 et seq.); reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; co-payment, co-insurance, deductible, or other cost sharing arrangement, as those terms are defined in § 38.2-3407.12; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost sharing levels that are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, if a health maintenance organization is federally qualified, and of nonfederally qualified health maintenance organizations, if a health maintenance organization is not federally qualified. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for health insurance issuers.

2. No law requiring the coverage or offering of coverage of a benefit or provider pursuant to § 38.2-3408 or 38.2-4221 shall apply to the essential or standard health care plan or riders thereof.

3. Every health insurance issuer offering group health insurance coverage shall, as a condition of transacting business in Virginia with small employers, offer and make available to small employers an essential and a standard health benefit plan, subject to the provisions of § 38.2-3432.2.

4. All essential and standard benefit plans issued to small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy, or plan, provided that no rider, separate policy, or plan shall reduce benefit or premium. A health insurance issuer shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure plans, to the Commission for approval in the same manner as required by § 38.2-316. Each rider, separate policy, or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy, or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a health insurance issuer, disapprove the continued use by the health insurance issuer of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

5. No health insurance issuer offering group health insurance coverage is required to offer coverage or accept applications pursuant to subdivisions 3 and 4:

a. From a small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a health insurance issuer offering group health insurance coverage from issuing coverage to a group prior to its anniversary date; or

b. If the Commission determines that acceptance of an application or applications would result in the

health insurance issuer being declared an impaired insurer.

A health insurance issuer offering group health insurance coverage that does not offer coverage pursuant to subdivision 5 b may not offer coverage to small employers until the Commission determines that the health insurance issuer is no longer impaired.

6. Every health insurance issuer offering group health insurance coverage shall uniformly apply the provisions of subdivision 5 and shall fairly market the essential and standard health benefit plans to all small employers in their service area of the Commonwealth. A health insurance issuer offering group health insurance coverage that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the health insurance issuer submits and the Commission approves a plan to fairly market to the health insurance issuer's service area.

7. No health maintenance organization is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 in the case of any of the following:

a. To small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;

b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas;

c. To small employers if the health maintenance organization is a federally qualified health maintenance organization and it demonstrates to the satisfaction of the Commission that the federally qualified health maintenance organization is prevented from doing so by federal requirement; however, any such exemption under this subdivision would be limited to the essential plan; or

d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the later of 180 days after closure to new applications or the date on which the health maintenance organization notifies the Commission that it has regained capacity to deliver services to small employers. In the case of a health maintenance organization doing business in the small employer market in one service area of the Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 6 apply.

8. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for health insurance issuers, agents, and third-party administrators, including requirements relating to the following:

a. Registration by each health insurance issuer offering group health insurance coverage with the Commission of its intention to offer health insurance coverage in the small group market under this article;

b. Publication by the Commission of a list of all health insurance issuers that offer coverage in the small group market, including a potential requirement applicable to agents, third-party administrators, and health insurance issuers that no health benefit plan may be sold to a small employer by a health insurance issuer not so identified as a health insurance issuer in the small group market;

c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers to information concerning this article;

d. To the extent deemed to be necessary to ensure the fair distribution of small employers among carriers, periodic reports by health insurance issuers about plans issued to small employers, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to small employers. Health insurance issuers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and

e. Methods concerning periodic demonstration by health insurance issuers offering group health insurance coverage that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

9. All essential and standard health benefits plans contracts delivered, issued for delivery, reissued, renewed, or extended in the Commonwealth on or after July 1, 2017, shall include coverage for 365 days of inpatient hospitalization for each covered individual during a 12-month period. If coverage under the essential or standard health benefits plan terminates while a covered person is hospitalized, the inpatient hospital benefits shall continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided or (ii) the day the covered person is no longer hospitalized as an inpatient.

§ 38.2-3432.1. Renewability.

A. Every health insurance issuer that offers health insurance coverage in the group market in this Commonwealth shall renew or continue in force such coverage with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, or contract holder, or where the health insurance issuer has not received timely premium payments;

2. When the health insurance issuer is ceasing to offer coverage in the small group market in accordance with subdivisions 9 and 10;

3. For fraud or misrepresentation by the employer, with respect to their coverage;

4. With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission;

7. When a health insurance issuer offers health insurance coverage in the group market through a network plan, and there is no longer an enrollee in connection with such plan who lives, resides, or works in the service area of the health insurance issuer (or in the area for which the health insurance issuer is authorized to do business) and, in the case of the group market, the health insurance issuer would deny enrollment with respect to such plan under the provisions of subdivision 9 or 10;

8. When health insurance coverage is made available in the group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this subdivision uniformly without regard to any health status related factor relating to any covered individual;

9. When a health insurance issuer decides to discontinue offering a particular type of group health insurance coverage in the group market in this Commonwealth, coverage of such type may be discontinued by the health insurance issuer in accordance with the laws of this Commonwealth in such market only if (i) the health insurance issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage; (ii) the health insurance issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in such market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under this subdivision, the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

10. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the group market in this Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only in accordance with the laws of this Commonwealth and if: (i) the health insurance issuer provides notice to the Commission and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and (ii) all health insurance issued or delivered for issuance in this Commonwealth in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed;

11. In the case of a discontinuation under subdivision 10 of this subsection in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market and this Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed;

12. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan or health insurance issuer offering group health insurance coverage in the group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with the laws of this Commonwealth and effective on a uniform basis among group health plans or health insurance issuers offering group health insurance coverage with that product; ~~or~~

13. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer*; or*

14. Benefits and premiums that have been added by rider to the essential or standard benefit plans issued to small employers shall be renewable at the sole option of the health insurance issuer.

B. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

§ 38.2-3432.2. Availability.

A. If coverage is offered under this article in the small employer market:

1. Such coverage shall be offered and made available to all the eligible employees of every small employer and their dependents, including late enrollees, that apply for such coverage. No coverage may be offered only to certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status; and

2. All products that are approved for sale in the small group market that the health insurance issuer is actively marketing must be offered to all small employers, and the health insurance issuer must accept any employer that applies for any of those products. This subdivision shall not apply to health insurance coverage or products offered by a health insurance issuer if such coverage or product is made available in the small group market only through one or more bona fide associations.

B. No coverage offered under this article shall exclude an employer based solely on the nature of the employer's business.

C. A health insurance issuer that offers health insurance coverage in a small group market through a network plan may:

1. Limit the employers that may apply for such coverage to those eligible individuals who live, work or reside in the service area for such network plan; and

2. Within the service area of such plan, deny such coverage to such employers if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

a. It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

b. It is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factors relating to such employees and dependents.

3. A health insurance issuer upon denying health insurance coverage in any service area in accordance with subdivision D 1, may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

D. A health insurance issuer may deny health insurance coverage in the small group market if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

1. It does not have the financial reserves necessary to underwrite additional coverage; and

2. It is applying this subdivision uniformly to all employers in the small group market in the Commonwealth consistent with the laws of this Commonwealth and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

E. A health insurance issuer upon denying health insurance coverage in accordance with subsection D in the Commonwealth may not offer coverage in the small group market for a period of 180 days after the date such coverage is denied or until the health insurance issuer has demonstrated to the satisfaction of the Commission that the health insurance issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

F. Nothing in this article shall be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules in connection with a health benefit plan offered in the small group market. As used in this article, the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of eligible individuals and the term "group participation rule" means a requirement relating to the minimum number of eligible employees that must be enrolled in relation to a specified percentage or number of eligible employees. Any employer contribution rule or group participation rule shall be applied uniformly among small employers without reference to the size of the small employer group, health status of the small employer group, or other factors.

~~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.~~

§ 38.2-3432.3. 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 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 § 38.2-4216.2 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 of this subsection or termination of coverage or employer contribution described in clause (ii) of subdivision 3 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 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.~~

§ 38.2-3433.1. Small employer market premium and disclosure provisions.

A. New or renewal premium rates for essential or standard health benefit plans issued by a health insurance issuer to a small employer not currently enrolled with that same health insurance issuer shall be based on a community rate subject to the following conditions:

1. A health insurance issuer may use the following risk classification factors in rating small groups: demographic rating, including age and gender, and geographic area rating. A health insurance issuer may not use claim experience, health status, duration, or other risk classification factors in rating such groups, except as provided in subdivision 2.

2. The premium rates charged by a health insurance issuer may deviate from the community rate filed by the health insurance issuer by not more than 20 percent above or 20 percent below such rate for claim experience, health status, and duration only during a rating period for such groups within a similar demographic risk classification for the same or similar coverage. Rates for a health benefit plan may vary on the basis of the number of the eligible employee's enrolled dependents.

3. Health insurance issuers shall apply rating factors consistently with respect to all small employers in a similar demographic risk classification. Adjustments in rates for claim experience, health status, and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer.

B. In connection with the offering for sale of any health benefit plan to a small employer, each health insurance issuer shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

1. The extent to which premium rates for a specific small employer are established or adjusted in part on the basis of the actual or expected variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of such small employer;

2. Provisions relating to renewability of policies and contracts; and

3. Provisions affecting any preexisting conditions provision.

C. Each health insurance issuer shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices pertaining to its small employer business, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

D. Each health insurance issuer shall file with the Commission annually on or before March 15 the community rates and an actuarial certification certifying that the health insurance issuer and its rates are in compliance with this article. A copy of such certification shall be retained by the health insurance issuer at its principal place of business.

E. A health insurance issuer shall make the information and documentation described in subsection C available for review by the Commission upon request.

§ 38.2-3436. Eligibility to enroll.

A. A health insurance issuer offering group health insurance coverage, may not establish rules for

eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the health status-related factors.

B. The provisions of this section shall not be construed:

1. To require a group health insurance coverage to provide particular benefits other than those provided under the terms of such plan or coverage; or

2. To prevent a health insurance issuer offering group health insurance coverage from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage rules for eligibility to enroll under a plan which includes rules defining any applicable waiting periods for such enrollment.

C. A health insurance issuer offering group health insurance coverage, may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

D. Nothing in subsection C shall be construed:

1. To restrict the amount that an employee may be charged for coverage under a group health plan or group health insurance coverage; or

2. To prevent a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

~~E. 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.~~

§ 38.2-3500. 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 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.~~

§ 38.2-3501. Policy forms; powers of Commission.

~~A.~~ Individual accident and sickness insurance policy forms and the rate manuals showing rules and classification of risks applicable to individual accident and sickness insurance policy forms shall be subject to the provisions of § 38.2-316. The Commission, subject to § 38.2-316, may disapprove or withdraw approval of any such policy form if it finds that the benefits provided in the policy form are or are likely to be unreasonable in relation to the premium charged. If the Commission disapproves a policy form or withdraws approval of a form, an insurer may proceed as indicated in § 38.2-1926.

~~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.~~

§ 38.2-3503. Required accident and sickness policy provisions.

~~A.~~ Except as provided in § 38.2-3505, each individual accident and sickness insurance policy

delivered or issued for delivery in this Commonwealth shall contain the provisions specified in this section using the same words which appear in this section. Provisions 1 through 12 shall apply to all such policies. In addition, provision 13 shall apply to all such policies that are delivered, issued for delivery, renewed, or extended in this Commonwealth on or after January 1, 2001. An insurer may substitute corresponding provisions of different wording approved by the Commission that are in each instance not less favorable in any respect to the insured or the beneficiary. These provisions shall be preceded individually by the caption "REQUIRED PROVISIONS" or by such appropriate individual or group captions or subcaptions as the Commission may approve.

1. Provision 1:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

2. Provision 2:

TIME LIMIT ON CERTAIN DEFENSES: (a) Misstatements in the application: After two years from the date of this policy, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability (as defined in the policy) that starts after the two-year period.

Provision 2 shall not be construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subdivisions 1, 2, 3, 4, and 5 of § 38.2-3504 in the event of misstatement with respect to age, occupation or other insurance.

Instead of Provision 2, a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (i) until at least age 50 or, (ii) for a policy issued after age 44, for at least five years from its date of issue, may contain the following provision, from which the clause in parentheses may be omitted at the insurer's option:

INCONTESTABLE:

(a) Misstatements in the application: After this policy has been in force for two years during the Insured's lifetime (excluding any period during which the Insured is disabled), the Company cannot contest the statements in the application.

PREEXISTING CONDITIONS:

(b) No claim for loss incurred or disability (as defined in the policy) that starts after one year from the date of issue of this policy will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

3. Provision 3:

GRACE PERIOD: This policy has a _____ day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following _____ days. During the grace period the policy shall continue in force.

In Provision 3 a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "a" and "day," and between "following" and "days." ~~However, if provisions of federal law require a policy to have a grace period in excess of one month, the period of time that the policy shall continue in force during the grace period shall not be required to exceed one month from the beginning of the grace period.~~

A policy that contains a cancellation provision may add, at the end of Provision 3: "subject to the right of the Company to cancel in accordance with the cancellation provision."

A policy in which the insurer reserves the right to refuse any renewal shall have, in Provision 3, the following sentence:

The grace period will not apply if, at least _____ days before the premium due date, the Company has delivered or has mailed to the Insured's last address shown in the Company's records written notice of the Company's intent not to renew this policy.

In the above sentence a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "least" and "days."

4. Provision 4:

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the Company or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the policy. If the Company or its agent requires an application for reinstatement, the Insured will be given a conditional receipt for the premium. If the application is approved the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Company has previously written the Insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that

starts more than 10 days after such date. In all other respects the rights of the Insured and the Company will remain the same, subject to any provisions noted or attached to the reinstated policy. Any premiums the Company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

The last sentence of Provision 4 may be omitted from any policy that the Insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least age 50, or (ii) for a policy issued after age 44, for at least five years from its effective date.

5. Provision 5:

NOTICE OF CLAIM: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to the Company at _____ (insert the location of such office as the insurer may designate for the purpose), or to the Company's agent. Notice should include the name of the Insured, and Claimant if other than the Insured, and the policy number.

Optional paragraph: If the Insured has a disability for which benefits may be payable for at least two years, at least once in every six months after the Insured has given notice of claim, the Insured must give the Company notice that the disability has continued. The Insured need not do this if legally incapacitated. The first six months after any filing of proof by the Insured or any payment or denial of a claim by the Company will not be counted in applying this provision. If the Insured delays in giving this notice, the Insured's right to any benefits for the six months before the date the Insured gives notice will not be impaired.

6. Provision 6:

CLAIM FORMS: When the Company receives the notice of claim, it will send the Claimant forms for filing proof of loss. If these forms are not given to the Claimant within 15 days after the giving of such notice, the Claimant shall meet the proof of loss requirements by giving the Company a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

7. Provision 7:

PROOFS OF LOSS: If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the Company within 90 days after the end of each period for which the Company is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. Provision 8:

TIME OF PAYMENT OF CLAIMS: After receiving written proof of loss, the Company will pay _____ (Insert period for payment which must not be less frequently than monthly) all benefits then due for _____ (Insert type of loss). Benefits for any other loss covered by this policy will be paid as soon as the Company receives proper written proof.

9. Provision 9:

PAYMENT OF CLAIMS: Benefits will be paid to the Insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or the Insured's estate.

Optional paragraph: If benefits are payable to the Insured's estate or a beneficiary who cannot execute a valid release, the Company can pay benefits up to $ _____ (insert an amount which shall not exceed $2,000), to someone related to the Insured or beneficiary by blood or by marriage whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any payment made in good faith.

Optional paragraph: The Company may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless the Insured directs otherwise in writing by the time proofs of loss are filed. The Company cannot require that the services be rendered by a particular health care services provider.

10. Provision 10:

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company at its own expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

11. Provision 11:

LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No legal action may be brought after three years from the time written proof of loss is required to be given.

12. Provision 12:

CHANGE OF BENEFICIARY: The Insured can change the beneficiary at any time by giving the

Company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

13. Provision 13:

CANCELLATION BY INSURED: The Insured may cancel this policy at any time by written notice delivered or mailed to the Company effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, the Company shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

~~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.~~

§ 38.2-3520. Coverage of preexisting conditions.

~~A.~~ Notwithstanding the provisions of § 38.2-3503, if an insurer elects to use a simplified application form, with or without a specific question as to the applicant's health, but without any detailed questions concerning the insured's health history or medical treatment history, the policy shall cover any loss occurring after twelve months from the effective date of coverage from any preexisting condition not specifically excluded from coverage by terms of the policy. Except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions.

~~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.~~

§ 38.2-3521.1. Group accident and sickness insurance definitions.

Except as provided in § 38.2-3522.1, no policy of group accident and sickness insurance shall be delivered in this Commonwealth unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

B. A policy which is:

1. Not subject to Chapter 37.1 (§ 38.2-3727 et seq.) of this title, and

2. Issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

(1) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(2) The debtors of one or more subsidiary corporations; and

(3) The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control.

b. The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The total amount of insurance payable with respect to an indebtedness shall not exceed the greater

of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy.

5. The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of the insurance shall be payable to the insured or the estate of the insured.

6. Notwithstanding the preceding provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

C. A policy issued to a labor union, or similar employee organization, which labor union or organization shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

1. The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

2. The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

D. A policy issued (i) to or for a multiple employer welfare arrangement, a rural electric cooperative, or a rural electric telephone cooperative as these terms are defined in 29 U.S.C. § 1002, or (ii) to a trust, or to the trustees of a fund, established or adopted by or for two or more employers, or by one or more labor unions of similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

1. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employee" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

E. 1. A policy issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations which association or trust shall be deemed the policyholder. The association or associations shall:

a. Have at the outset a minimum of 100 persons;

b. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;

c. Have been in active existence for at least five years;

d. Have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees;

e. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

f. Makes health insurance coverage offered through the association available to all members

regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

g. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

h. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

2. The policy shall be subject to the following requirements:

a. The policy may insure members of such association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

3. Except as provided in subdivision 4 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

4. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

F. A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees, or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

1. The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

2. The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision 3 of this subsection, must insure all eligible members.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

G. A policy issued to a health maintenance organization as provided in subsection B of § 38.2-4314.

H. A policy of blanket insurance issued in accordance with § 38.2-3521.2.

~~I. 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.~~

§ 38.2-3522.1. Limits of group accident and sickness insurance.

Group accident and sickness insurance offered to a resident of this Commonwealth under a group accident and sickness insurance policy issued to a group other than one described in § 38.2-3521.1 shall be subject to the following requirements:

A. No such group accident and sickness insurance policy shall be delivered in this Commonwealth unless the Commission finds that:

1. The issuance of such group policy is not contrary to Virginia's public policy and is in the best interest of the citizens of this Commonwealth;

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

Insurers filing policy forms seeking approval under the provisions of this subsection shall accompany the forms with a certification, signed by the officer of the company with the responsibility for forms compliance, in which the company certifies that each such policy form will be issued only where the requirements set forth in subdivisions 1 through 3 of this subsection have been met.

B. No such group accident and sickness insurance coverage may be offered in this Commonwealth by an insurer under a policy issued in another state unless this Commonwealth or another state having requirements substantially similar to those contained in subdivisions 1, 2, and 3 of subsection A has made a determination that such requirements have been met.

1. An insurer offering group accident and sickness insurance coverage in this Commonwealth under this subsection shall file a certification, signed by the officer of the company having responsibility for forms compliance, in which the company certifies that all group insurance coverage marketed to residents of this Commonwealth under policies which have not been approved by this Commonwealth will comply with the provisions of § 38.2-3521.1 or have met the requirements set forth in subdivisions A 1 through A 3 of this section, and which clearly demonstrates that the substantially similar requirements of the state in which the contract will be issued have been met. The certification shall be accompanied by documentation from such state, evidencing the determination that such requirements have been met.

2. An insurer offering group accident and sickness insurance in this Commonwealth under this subsection that is unable to provide the documentation required in subdivision 1 of this subsection shall be required to file policy forms consistent with requirements in § 38.2-316 which are imposed on

policies issued in Virginia. The policy shall be required to be approved as meeting all requirements of this title prior to its being offered to residents of this Commonwealth.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

D. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

~~E. 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.~~

§ 38.2-3523.4. Minimum number of persons covered.

~~A.~~ A group accident and sickness insurance policy shall on the issue date and at each policy anniversary date, cover at least two persons, other than spouses or minor children, unless such spouse or minor child is determined to be an eligible employee as defined in § 38.2-3431.

~~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.~~

§ 38.2-3525. 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.~~

§ 38.2-3540.2. Employee wellness program.

~~A.~~ Each group accident and sickness insurance policy and health care plan may provide a premium discount to every employer instituting and maintaining an employee wellness program satisfying such criteria as each insurer may establish. An employer instituting and maintaining an employee wellness program in accordance with the insurer's criteria may require that any employee wishing to enroll in such program undergo a health assessment as a condition of enrollment.

~~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.~~

§ 38.2-3541. Continuation on termination of eligibility.

~~A.~~ Each group hospital policy, group medical and surgical policy, or group major medical policy delivered or issued for delivery in the Commonwealth, or renewed, reissued, or extended if already issued, shall contain ~~a provision for continuation of coverage under the group policy~~, *subject to the policyholder's selection, one of the options set forth in this section. Option 1 shall apply* if the insurance on a person covered under such a policy ceases because of the termination of the person's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits, *unless such termination is due to termination of the group policy under circumstances in which the insured person is insurable under other replacement group coverage or health care plan without waiting periods or preexisting conditions under the replacement coverage or plan. Option 2 shall apply if the insurance on a person covered under such a policy that remains in force ceases because of the termination of the*

person's eligibility for coverage prior to that person becoming eligible for Medicare or Medicaid benefits. ~~This provision~~ *Option 2* shall not be applicable if the group policyholder is required by federal law to provide for continuation of coverage under its group health plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

~~B. The insured's~~ *1. Option 1: To have the insurer issue him, without evidence of insurability, an individual accident and sickness insurance policy in the event that the insurer is not exempt under § 38.2-3416.1 and offers such policy, subject to the following requirements:*

a. The application for the policy shall be made, and the first premium paid to the insurer, within 31 days after issuance of the written notice required in subdivision 3, but in no event beyond the 60-day period following the date of the termination of the person's eligibility;

b. The premium on the policy shall be at the insurer's then customary rate applicable (i) to such policies, (ii) to the class of risk to which the person then belongs, and (iii) to his or her age on the effective date of the policy;

c. The policy shall not result in over-insurance on the basis of the insurer's underwriting standards at the time of issue;

d. The benefits under the policy shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;

e. The policy shall extend coverage to the same family members that were insured under the group policy; and

f. Coverage under this option shall be effected in such a way as to result in continuous coverage from the date of the insured's termination of eligibility for such insured if requested and paid for by the insured.

2. Option 2: To have his present coverage ~~shall continue~~ under the policy *continued* for a period of 12 months immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

~~1.~~ *a.* The application and payment for the extended coverage is made to the group policyholder within 31 days after issuance of the written notice required in ~~subsection C~~ *subdivision 3*, but in no event beyond the 60-day period following the date of the termination of the person's eligibility;

~~2.~~ *b.* Each premium for such extended coverage is timely paid to the group policyholder on a monthly basis during the 12-month period;

~~3.~~ *c.* The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative fee not to exceed two percent of the current rate; and

~~4.~~ *d.* Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three-month period immediately preceding termination of eligibility.

~~C.~~ *3.* The group policyholder shall provide each employee or other person covered under such a policy written notice of the availability of ~~continuation of coverage~~ *the option chosen* and the procedures and timeframes for obtaining continuation *or conversion* of the group policy. Such notice shall be provided within 14 days of the policyholder's knowledge of the employee's or other covered person's loss of eligibility under the policy.

§ 38.2-3541.3. Continuation following involuntary termination of employment; special circumstances.

A. For purposes of meeting the definition of "COBRA continuation coverage" in Title III of Division B of the American Recovery and Reinvestment Act of 2009, P.L. 111-5 (the Act), employees who are involuntarily terminated during the period beginning September 1, 2008, and ending December 31, 2009, or during any period for which premium assistance is specified by the Act as later amended, shall be offered the option to continue their existing group health insurance coverage subject to the following:

1. Coverage shall continue for a period of up to nine months, or any additional period specified by the Act as later amended, (i) following the date of involuntary termination for those terminated on or after the date of enactment of this section or (ii) following the date of the notification required pursuant to subdivision 3, contingent upon the involuntarily terminated employee's eligibility for premium assistance under the Act;

2. Premium payments (i) may be paid on a monthly basis to the group policyholder and (ii) shall not exceed 102 percent of the insurer's current premium rate applicable to the group policy;

3. Employers shall provide notification of the availability of continuation under this section as follows:

a. Notification shall be provided to those employees whose employment was terminated on or after September 1, 2008, and prior to February 17, 2009, in accordance with Section 3001 of the Act;

b. Notification shall be provided to those employees whose employment was terminated on or after February 17, 2009, and prior to the date of enactment of this section, no later than 60 days following

the date of enactment of this section or the employee's termination, whichever is later; and

c. Notification shall be provided to those employees whose employment was terminated after the date of enactment of this section no later than 30 days following the date of the employee's termination;

4. The employee shall elect this continued coverage no later than 60 days following notification of plan enrollment options; and

5. All other provisions, restrictions, and limitations contained in the Act shall apply.

B. The provisions of this section shall apply only to employees of small employers whose group health insurance coverage does not provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

C. As used in this section, "group health insurance coverage" and "health insurance issuer" shall have the same meaning as provided in § 38.2-3431.

§ 38.2-3551. Definitions.

~~A.~~ As used in this article:

"Eligible dependent" means an individual who may be covered as a dependent under a group health policy or policies and who is eligible, as determined by a small employer health group cooperative, for coverage as a dependent of an eligible employee under a group health policy or policies issued to or through such small employer health group cooperative.

"Eligible employee" means an employee who works for a small employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary, or substitute employee.

"Employer-member" means a small employer participating in a small employer health group cooperative.

"Group health policy" or "policy" means a group insurance policy providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, a group accident and sickness insurance policy or subscription contract, and a group health care plan for health care services or limited health care services provided by a health maintenance organization. For the purposes of this article, a group health policy or policy shall also mean a policy or plan provided by a dental or optometric services plan, dental plan organization, and a health maintenance organization offering limited health care services as defined in § 38.2-4300.

"Health insurance issuer" or "issuer" means a company authorized to issue coverage under Article 3 (§ 38.2-3521.1 et seq.) of Chapter 35, Chapter 42 (§ 38.2-4200 et seq.), Chapter 43 (§ 38.2-4300 et seq.), Chapter 45 (§ 38.2-4500 et seq.), or Chapter 61 (§ 38.2-6100 et seq.) of this title.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;
2. Medical condition, including both physical and mental illnesses;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of domestic violence; or
8. Disability.

"Service area" means the geographic area within which a health insurance issuer is authorized to sell a group health policy or policies.

"Small employer" means, in connection with a group health policy with respect to a calendar year and a plan year, an employer who employed an average of at least ~~one~~ *two* but not more than 50 employees on business days during the preceding calendar year and who employs at least ~~one employee~~ *two employees* on the first day of the plan year.

"Small employer health group cooperative" or "cooperative" means an entity authorized by its employer-members to negotiate with health insurance issuers on their behalf as to the terms, including premium rates, under which a group health policy or policies may be issued, providing coverage for the eligible employees of such employer-members and their eligible dependents.

~~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.~~

§ 38.2-4109. Organization of domestic society on or after October 1, 1986.

A. On or after October 1, 1986, seven or more citizens of the United States, a majority of whom are citizens of this Commonwealth, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgement of deeds, articles of incorporation, which shall state:

1. The proposed corporate name of the society, which shall not so closely resemble the name of any other society or insurer as to be misleading or confusing;

2. The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter;

3. The names and residences of the incorporators and the names, residences and official titles of all officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

B. Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the Commission, which may require any further information it deems necessary. The bond, with sureties approved by the Commission, shall be not less than $50,000 nor more than $200,000, as required by the Commission. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the Commission shall so certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

C. No preliminary certificate of authority granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the Commission upon cause shown, unless the 500 required applicants have been secured and the organization has been duly completed. The articles of incorporation and all other proceedings under those articles shall become void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society has completed its organization and received a certificate of authority to do business.

D. Upon receipt of a preliminary certificate of authority from the Commission, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

1. Actual bona fide applicants for benefits have been secured on not less than 500 applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

2. At least 10 subordinate lodges have been established into which the 500 applicants have been admitted;

3. There has been submitted to the Commission, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and their premiums; and

4. It has been shown to the Commission, by sworn statement of the treasurer, or corresponding officer of such society, that at least 500 applicants have each paid in cash at least one regular monthly premium, which shall total at least $150,000. Advance premiums shall be held in trust during the period of organization and, if the society has not qualified for a certificate of authority within one year, such premiums shall be returned to the applicants.

E. The Commission may examine and require any further information it deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the Commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to do business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The Commission shall cause a record of such certificate of authority to be made. A certified copy of such record shall have the same effect as the original certificate of authority.

F. Any incorporated society authorized to do business in this Commonwealth at the time this chapter becomes effective shall not be required to reincorporate.

~~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.~~

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

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, ~~38.2-316.1,~~ 38.2-322, 38.2-325, ~~38.2-326,~~ 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1442, 38.2-1446,

38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through ~~38.2-3454~~ *38.2-3437*, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, ~~Chapter 35.1 (§ 38.2-3556 et seq.),~~ §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.) ~~of this title~~, *and § 38.2-5901.3* shall apply to the operation of a plan.

§ 38.2-4216.2. 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:

"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 that 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 shall prominently advertise the availability of its open enrollment contracts at least 12 times annually in a newspaper or newspapers of general circulation throughout its service area in the Commonwealth. The content and format of such advertising shall be generally approved by the Commission.

[~~F.~~ *E.*] *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 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 § 58.1-2501.*

[~~G.~~ *F.*] *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.*

§ 38.2-4217. Reports.

A. In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file on a quarterly basis any additional reports, exhibits or statements the Commission considers necessary to furnish full information concerning the condition, solvency, experience, transactions or affairs of the nonstock corporation. The Commission shall establish deadlines for submitting any additional reports, exhibits or statements. The Commission may require verification by any officers of the nonstock corporation the Commission designates.

B. In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file annually, on or before June 1, an annual statement, signed by two of its principal officers subject to § 38.2-1304, showing:

1. The number of Virginia subscribers by the following type of contract or its equivalent:

a. Individual, open enrollment; ~~and~~

b. Medicare, extended, under 65 disabled; *and*

c. Individual conversion subscribers;

2. The subscriber income and benefit payments in the aggregate for the types of contracts listed above subject to specific breakdown by type of contract as requested by the Commission; and

3. Expenditures for providing public services, in addition to open enrollment, to the community.

§ 38.2-4229.1. Conversion to domestic mutual insurer.

A. Any domestic nonstock corporation subject to the provisions of this chapter that has the surplus

required by § 38.2-1030 for domestic mutual insurers issuing policies without contingent liability may, at its option and without reincorporation, convert to a domestic mutual insurer by following the procedure set forth in this section.

B. Any nonstock corporation eligible to convert to a domestic mutual insurer under subsection A may effect such conversion by amending its articles of incorporation to delete any reference to this chapter and to comply with the provisions of § 38.2-1002 relating to the articles of incorporation of a domestic mutual insurer. Upon the issuance of a certificate of amendment by the Commission, the conversion shall be effective, such nonstock corporation shall become subject to all of the provisions of this title relating to domestic mutual insurers, and *except as provided in subsection D,* such nonstock corporation shall no longer be subject to the provisions of this chapter.

C. If any nonstock corporation converts from a health services plan organized under this chapter to a domestic mutual insurer, then at least 90 days prior to the effective date of conversion, the nonstock corporation shall comply with § 38.2-316 by filing with the Commission copies of all policies of insurance that it proposes to issue after the effective date of conversion. All subscription contracts issued and outstanding as of the effective date of conversion shall remain in force in accordance with their terms until the expiration or termination of such contracts.

D. *Any nonstock corporation that offers an open enrollment program under § 38.2-4216.2 shall, directly or through a subsidiary, continue to offer such program notwithstanding its conversion to a domestic mutual insurer. If any such domestic mutual insurer converts to a stock insurer, it shall, directly or through a subsidiary, continue to offer such program notwithstanding its conversion to a stock insurer. No such insurer shall discontinue the open enrollment program required by § 38.2-4216.2 without first giving the Commission 24 months' prior written notice. For so long as the insurer continues to offer such open enrollment program, the license tax imposed on the direct gross premium income of the insurer and its subsidiaries from accident and sickness insurance shall be three-fourths of one percent on premium income derived from individual accident and sickness insurance policies and from open enrollment contracts as defined in § 38.2-4216.2, and two and one-fourth percent on other premium income from accident and sickness insurance.*

E. No policy of accident and sickness insurance issued by a nonstock corporation after its conversion to a domestic mutual insurer shall deny the policyholder the right to assign his benefit, except that denial may be made where the benefit is 80 percent of covered charges or greater.

§ 38.2-4306. Evidence of coverage and charges for health care services.

A.1. Each subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the Commission, subject to the provisions of subsection C of this section. Any evidence of coverage for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, is excluded from the provisions of this section.

3. No evidence of coverage shall contain provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.

4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

a. The health care services and any insurance or other benefits to which the enrollee is entitled under the health care plan;

b. Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature, or both;

c. Where and in what manner information is available as to how services may be obtained;

d. The total amount of payment for health care services and any indemnity or service benefits that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory for group certificates;

e. A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee; ~~and~~

f. A list of providers and a description of the service area which shall be provided with the evidence of coverage, if such information is not given to the subscriber at the time of enrollment*; and*

g. Any right of subscribers covered under a group contract to convert their coverages to an individual contract issued by the health maintenance organization.

B. Pursuant to this subsection:

1. No schedule of charges or amendment to the schedule of charges for enrollee coverage for health care services may be used in conjunction with any health care plan until a copy of the schedule, or its amendment, has been filed with the Commission. Any schedule of charges or amendment to the schedule of charges for enrollees in the plans administered by the Department of Medical Assistance

Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, is excluded from the provisions of this subsection.

2. The charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applying to an enrollee in a group health plan shall not be individually determined based on the status of his health. A certification on the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information. This certification shall be prepared by a qualified actuary or other qualified professional approved by the Commission.

C. The Commission shall, within a reasonable period, approve any form if the requirements of subsection A of this section are met. It shall be unlawful to issue a form until approved. If the Commission disapproves a filing, it shall notify the filer. The Commission shall specify the reasons for its disapproval in the notice. A written request for a hearing on the disapproval may be made to the Commission within 30 days after notice of the disapproval. If the Commission does not disapprove any form within 30 days of the filing of such form, it shall be deemed approved unless the filer is notified in writing that the waiting period is extended by the Commission for an additional 30 days. Filing of the form means actual receipt by the Commission.

D. The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing made under this section.

~~E. 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.~~

§ 38.2-4310. Protection against insolvency.

A. Each health maintenance organization shall deposit and maintain acceptable securities with the State Treasurer in amounts prescribed by § 38.2-4310.1. The deposit shall be held as a special fund in trust, as a guarantee that the obligations to the enrollees who are residents of this Commonwealth will be performed. The securities shall be deposited pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership interests effected on the records of a depository and its participants pursuant to rules and procedures established by the depository. Upon a determination of insolvency or action by the Commission pursuant to § 38.2-4317, the deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of covered services to enrollees. If a health maintenance organization is placed in receivership, the deposit shall be an asset subject to the provisions of Chapter 15 (§ 38.2-1500 et seq.) ~~of this title~~.

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

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

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

3. Acceptable letters of credit; or

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

C. 1. In the event of an insolvency of a health maintenance organization, all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a 30-day enrollment period commencing upon a date to be prescribed by the Commission. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates then in effect for its enrollees in such group.

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

3. The Commission may also allocate equitably the insolvent health maintenance organization's

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

D. 1. Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

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

§ 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 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 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.~~

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, ~~38.2-316.1,~~ 38.2-322, 38.2-325, ~~38.2-326,~~ 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 5.1 (§ 38.2-1334.3 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through ~~38.2-3454~~ *38.2-3437,* 38.2-3500, subdivision 13

of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, *38.2-3541.3*, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, ~~Chapter 35.1 (§ 38.2-3556 et seq.),~~ Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.), *and § 38.2-5901.3* shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 5.1 (§ 38.2-1334.3 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.), *and 38.2-5901.3* shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

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

§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, ~~38.2-326,~~ 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, Articles 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 6 (§ 38.2-1335 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.1, 38.2-3407.4, 38.2-3407.10, 38.2-3407.13, 38.2-3407.14, 38.2-3407.15, 38.2-3407.17, 38.2-3407.19, 38.2-3415, 38.2-3541, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.), *and § 38.2-5901.3* shall apply to the operation of a plan.

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

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

D. The provisions of § 38.2-3407.1 shall apply to claim payments made on or after January 1, 2014. No optometric or dental services plan shall be required to pay interest computed under § 38.2-3407.1 if the total interest is less than $5.

CHAPTER 59.

~~OFFICE OF THE MANAGED CARE OMBUDSMAN~~ *INDEPENDENT EXTERNAL REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS.*

§ 38.2-5900. Definitions.

As used in this chapter:

"Covered person" means an individual, whether a policyholder, subscriber, enrollee, covered dependent, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan as defined in and subject to regulation under Chapter 58 *(§ 38.2-5800 et seq.)*, when such coverage is provided under a contract issued in ~~this~~ *the* Commonwealth.

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

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

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

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

§ 38.2-5901.1. Review by the Bureau of Insurance.

A. A covered person or a treating health care provider, with the consent of the covered person, may appeal to the Bureau of Insurance for review of any final adverse decision in accordance with regulations promulgated by the Commission concerning a health service for which the actual cost to the covered person would exceed $300 if the final adverse decision is not reversed, determined in accordance with regulations adopted by the Commission. The appeal shall be filed within 30 days of the final adverse decision, shall be in writing on forms prescribed by the Bureau of Insurance, shall include a general release executed by the covered person for all medical records pertinent to the appeal, and shall be accompanied by a $50 filing fee. The fee shall be collected by the Bureau of Insurance and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. The Bureau of Insurance may, for good cause shown, waive or refund the filing fee upon a finding that payment of the filing fee will cause undue financial hardship for the covered person or if the appeal is not accepted for review. The Bureau of Insurance shall provide a copy of the written appeal to the utilization review entity that made the final adverse decision.

B. The Bureau of Insurance or its designee shall conduct a preliminary review of the appeal to determine (i) whether the applicant is a covered person or a treating health care provider acting with the consent of the covered person, (ii) whether the benefit or service that is the subject of the application reasonably appears to be a covered service for which the actual cost to the covered person would exceed $300 if the final adverse decision is not reversed, (iii) whether all complaint and appeal procedures available under Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 have been exhausted, and (iv) whether the application is otherwise complete and filed in compliance with this section. Such preliminary review shall be conducted within 10 working days of receipt of all information and documentation necessary to conduct a preliminary review. The Bureau of Insurance shall not accept for review any application that fails to meet the criteria set forth in this subsection. Within five working days of completion of the preliminary review, the Bureau of Insurance or its designee shall notify the applicant and the utilization review entity in writing whether the appeal has been accepted for review and, if not accepted, the reasons therefor.

C. The covered person, the treating health care provider, and the utilization review entity shall provide copies of the medical records relevant to the final adverse decision to the Bureau of Insurance

within 20 working days after the Bureau of Insurance has mailed written notice of its acceptance of the appeal. Failure to comply with such request within 20 working days from the date of such request may result in dismissal of the appeal or reversal of the final adverse decision, in the discretion of the Commissioner or his designee. The confidentiality of such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth. The Bureau of Insurance or its designee may, if deemed necessary, request additional medical records from the covered person, any treating health care provider, or the utilization review entity. Failure to comply with such request within 20 working days from the date of such request may result in dismissal of the appeal or reversal of the final adverse decision in the discretion of the Commissioner or his designee.

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

§ 38.2-5901.2. Appeals; impartial health entity.

A. The Bureau of Insurance shall contract with one or more impartial health entities for the purpose of performing the review of final adverse decisions. The Commission shall adopt regulations to assure that the impartial health entity conducting the review has adequate standards, credentials, and experience for such review. The impartial health entity shall examine the final adverse decision to determine whether the decision is objective, clinically valid, compatible with established principles of health care, and appropriate under the terms of the contractual obligations to the covered person. The impartial health entity shall review the written appeal; the response of the utilization review entity; any affidavits that either the covered person, the treating health care provider, or the utilization review entity may file with the Bureau of Insurance; and such medical records as the impartial health entity shall deem appropriate. The impartial health entity shall issue its written recommendation affirming, modifying, or reversing the final adverse decision within 30 working days of the date that the impartial review entity has received from all parties all documentation and information necessary for it to complete its review. The Commissioner or his designee, on the basis of such recommendation, shall issue a written ruling affirming, modifying, or reversing the final adverse decision within 10 working days after his receipt of the recommendation of the impartial review entity; however, if the regular process for the issuance of such written ruling will delay the rendering of treatment for a patient whose condition would be terminal without the treatment, the Commissioner or his designee shall issue his written ruling affirming, modifying, or reversing the final adverse decision no later than one business day following the receipt of such recommendation. Such written ruling shall not be construed as a final finding, order, or judgment of the Commission and shall be exempt from the application of the Administrative Process Act (§ 2.2-4000 et seq.). The written ruling of the Commissioner or his designee shall affirm the recommendations of the impartial health entity unless the Commissioner or his designee finds in his ruling that the impartial health entity exceeded its authority or acted arbitrarily or capriciously. The written ruling of the Commissioner or his designee shall bind the covered person and the utilization review entity to the extent to which each would have been obligated by a judgment entered in an action at law or in equity with respect to the issues that the impartial review entity may examine when reviewing a final adverse decision under this section. Failure by the utilization review entity to comply with the written ruling of the Commissioner or his designee within 30 days of the date of such ruling, or within three business days following receipt by the utilization review entity of an expedited ruling, shall be deemed a knowing and willful violation of this section. The impartial health entity shall not be affiliated or a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

B. The Bureau of Insurance shall contract with one or more impartial health entities such as medical peer review organizations and independent utilization review companies that the Bureau of Insurance shall determine to possess the necessary credentials and otherwise be qualified to perform such review. Prior to assigning an appeal to an impartial health entity, the Bureau of Insurance shall verify that the impartial health entity conducting the review of a final adverse decision has no relationship or association with (i) the utilization review entity or any officer, director, or manager of such utilization review entity; (ii) the covered person; (iii) the treating health care provider or any of its employees or affiliates; (iv) the medical care facility at which the covered service would be provided, or any of its employees or affiliates; or (v) the development or manufacture of the drug, device, procedure, or other therapy that is the subject of the final adverse decision. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

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

D. Any utilization review entity that is required to provide previously denied services as a result of the review by the impartial health entity shall be subject to payment of such fees as the Commissioner,

in his sole discretion, shall deem appropriate to cover the costs of the review. All such fees shall be collected by the Bureau of Insurance and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. Failure by the utilization review entity to remit such fee within 30 days of the date notice of such fee is mailed to the utilization review entity shall be deemed a knowing and willful violation of this section.

§ 38.2-5901.3. Assessment to fund appeals.

A. Each licensed insurer writing insurance as defined in § 38.2-109 and that is subject to subsection B of § 38.2-5801, each health maintenance organization organized in accordance with the provisions of Chapter 43 (§ 38.2-4300 et seq.), and each nonstock corporation organized in accordance with the provisions of Chapter 42 (§ 38.2-4200 et seq.) or Chapter 45 (§ 38.2-4500 et seq.) and that is subject to subsection B of § 38.2-5801 shall pay, in addition to any other assessments provided in this title, an assessment in an amount not to exceed 0.015 percent of the direct gross premium income for such insurance written during the preceding calendar year. The assessment shall be apportioned and assessed and paid as prescribed by § 38.2-403.

B. The assessments made by the Commission under subsection A and paid into the state treasury shall be deposited to a special fund designated "Bureau of Insurance Special Fund-State Corporation Commission," and out of such special fund and the unexpended balance thereof shall be appropriated the sums necessary for the regulation, supervision, and examination of all entities subject to regulation under this title.

§ 38.2-5901.4. Regulations.

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

§ 58.1-2501. Levy of license tax.

A. For the privilege of doing business in the Commonwealth, there is hereby levied on every insurance company defined in § 38.2-100 which issues policies or contracts for any kind of insurance classified and defined in §§ 38.2-102 through 38.2-134 and on every corporation which issues subscription contracts for any kind of plan classified and defined in §§ 38.2-4201 and 38.2-4501, an annual license tax as follows:

1. For any kind of insurance classified and defined in §§ 38.2-109 through 38.2-134 or Chapters 44 (§ 38.2-4400 et seq.) and 61 (§ 38.2-6100 et seq.) of Title 38.2, except workers' compensation insurance on which a premium tax is imposed under the provisions of § 65.2-1000, such company shall pay a tax of two and three-fourths percent of its subscriber fee income or direct gross premium income on such insurance for each taxable year through 1988. For taxable year 1989 and each taxable year thereafter, such company shall pay a tax of two and one-fourth percent of its subscriber fee income or direct gross premium income on such insurance;

2. For policies or contracts for life insurance as defined in § 38.2-102, such company shall pay a tax of two and one-fourth percent of its direct gross premium income on such insurance. However, with respect to premiums paid for additional benefits in the event of death, dismemberment or loss of sight by accident or accidental means, or to provide a special surrender value, special benefit or an annuity in the event of total and permanent disability, the rate of tax shall be two and three-fourths percent for each taxable year beginning January 1, 1987, through December 31, 1988, and two and one-fourth percent for taxable year beginning January 1, 1989, and each taxable year thereafter;

3. For policies or contracts providing industrial sick benefit insurance as defined in § 38.2-3544, such company shall pay a tax of one percent of its direct gross premium income on such insurance. No company, however, doing business on the legal reserve plan, shall be required to pay any licenses, fees or other taxes in excess of those required by this section on such part of its business as is industrial sick benefit insurance as defined in § 38.2-3544; but any such company doing business on the legal reserve plan shall pay on all industrial sick benefit policies or contracts on which the sick benefit portion has been cancelled as provided in § 38.2-3546, or which provide a greater death benefit than $250 or a greater weekly indemnity than $10, and on all other life, accident and sickness insurance, the same license or other taxes as are required by this section; and

4. For subscription contracts for any kind of plan classified and defined in § 38.2-4201 or § 38.2-4501, such corporation shall pay a tax of two and one-fourth percent of its direct gross subscriber fee income derived from subscription contracts issued to primary small groups as defined in § 38.2-3431 and three-fourths of one percent of its direct gross subscriber fee income derived from other subscription contracts for taxable year 1997. For each of taxable years 1998 through 2013 *and 2018 and thereafter*, such corporation shall pay a tax of three-fourths of one percent of its direct gross subscriber fee income derived from subscription contracts issued to individuals and from open enrollment contracts as defined in § [~~38.2-4216.1~~ *38.2-4216.2*] , and two and one-fourth percent of its direct gross subscriber fee

income derived from other subscription contracts. ~~For each taxable year thereafter, such corporation shall pay a tax of two and one-fourth percent of its direct gross subscriber fee income derived from all subscription contracts.~~ The declaration of estimated tax pursuant to this subsection shall commence on or before April 15, 1988.

B. Notwithstanding any other provisions of this section, any domestic insurance company doing business solely in the Commonwealth which is purely mutual, has no capital stock and is not designed to accumulate profits for the benefit of or pay dividends to its members, and any domestic insurance company doing business solely in the Commonwealth, with a capital stock not exceeding $25,000 and which pays losses with assessments against its policyholders or members, shall pay an annual license tax of one percent of its direct gross premium income.

2. That §§ 38.2-316.1 and 38.2-326, Articles 6 (§§ 38.2-3438 through 38.2-3454.1) and 7 (§§ 38.2-3455 through 38.2-3460) of Chapter 34 of Title 38.2, and Chapter 35.1 (§§ 38.2-3556 through 38.2-3571) of Title 38.2 of the Code of Virginia are repealed.

3. That the provisions of this act shall become effective on the later of July 1, 2017, or the effective date of federal legislation repealing the Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

4. That, to the extent that the provisions of this act apply to accident and sickness insurance policies, subscription contracts, or health care plans for health care services issued in the Commonwealth, such provisions shall apply to any policy, contract, or plan delivered, issued for delivery, reissued, or extended on or after the January 1 next following the effective date of this act determined in accordance with the third enactment of this act, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.