19103088D

SENATE BILL NO. 1359

Offered January 9, 2019

Prefiled January 8, 2019

A BILL to amend and reenact §§ 32.1-102.1, 32.1-102.1:1, 38.2-4214, 38.2-4319, and 54.1-2910.01 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-102.3:1.2 and by adding in Chapter 34 of Title 38.2 an article numbered 8, consisting of sections numbered 38.2-3461 through 38.2-3464, relating to facilities providing imaging services; shared savings; exemption from certificate of public need.

Patron—Wagner

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-102.1, 32.1-102.1:1, 38.2-4214, 38.2-4319, and 54.1-2910.01 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-102.3:1.2 and by adding in Chapter 34 of Title 38.2 an article numbered 8, consisting of sections numbered 38.2-3461 through 38.2-3464, as follows:

§ 32.1-102.1. Definitions.

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

"Bad debt" means revenue amounts deemed uncollectable as determined after collection efforts based upon sound credit and collection policies.

"Certificate" means a certificate of public need for a project required by this article.

"Charity care" means health care services delivered to a patient who has a family income at or below 200 percent of the federal poverty level and for which it was determined that no payment was expected (i) at the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person or (ii) at some time following the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person. "Charity care" does not include care provided for a fee subsequently deemed uncollectable as bad debt. For a nursing home as defined in § 32.1-123, "charity care" means care at a reduced rate to indigent persons.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Medical care facility," as used in this title, means any institution, place, building or agency, whether or not licensed or required to be licensed by the Board or the Department of Behavioral Health and Developmental Services, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated persons who are injured or physically sick or have mental illness, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. For purposes of this article, only the following medical care facilities shall be subject to review:

1. General hospitals.
2. Sanitariums.
3. Nursing homes.
4. Intermediate care facilities, except those intermediate care facilities established for individuals with intellectual disability (ICF/IID) that have no more than 12 beds and are in an area identified as in need of residential services for individuals with intellectual disability in any plan of the Department of Behavioral Health and Developmental Services.
5. Extended care facilities.
6. Mental hospitals.
7. Facilities for individuals with developmental disabilities.
8. Psychiatric hospitals and intermediate care facilities established primarily for the medical,

psychiatric or psychological treatment and rehabilitation of individuals with substance abuse.

9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or such other specialty services as may be designated by the Board by regulation.

10. Rehabilitation hospitals.

11. Any facility licensed as a hospital.

The term "medical care facility" does not include any facility of (i) the Department of Behavioral Health and Developmental Services; (ii) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Behavioral Health and Developmental Services' Comprehensive State Plan; (iii) an intermediate care facility for individuals with intellectual disability (ICF/IID) that has no more than 12 beds and is in an area identified as in need of residential services for individuals with intellectual disability in any plan of the Department of Behavioral Health and Developmental Services; (iv) a physician's office, except that portion of a physician's office described in subdivision 9 of the definition of "medical care facility"; (v) the Wilson Workforce and Rehabilitation Center of the Department for Aging and Rehabilitative Services; (vi) the Department of Corrections; or (vii) the Department of Veterans Services. "Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.

"Project" means:

1. Establishment of a medical care facility;

2. An increase in the total number of beds or operating rooms in an existing medical care facility;

3. Relocation of beds from one existing facility to another, provided that "project" does not include the relocation of up to 10 beds or 10 percent of the beds, whichever is less, (i) from one existing facility to another existing facility at the same site in any two-year period, or (ii) in any three-year period, from one existing nursing home facility to any other existing nursing home facility owned or controlled by the same person that is located either within the same planning district, or within another planning district out of which, during or prior to that three-year period, at least 10 times that number of beds have been authorized by statute to be relocated from one or more facilities located in that other planning district and at least half of those beds have not been replaced, provided further that, however, a hospital shall not be required to obtain a certificate for the use of 10 percent of its beds as nursing home beds as provided in § 32.1-132;

4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;

5. Introduction into an existing medical care facility of *(i)* any new ~~cardiac catheterization,~~ computed tomographic (CT) scanning~~, stereotactic radiosurgery, lithotripsy~~, magnetic resonance imaging (MRI), magnetic source imaging (MSI), ~~medical rehabilitation, neonatal special care, obstetrical, open heart surgery,~~ positron emission tomographic (PET) scanning, ~~psychiatric, organ or tissue transplant service, radiation therapy, stereotactic radiotherapy, proton beam therapy,~~ *or* nuclear medicine imaging~~, except for the purpose of nuclear cardiac imaging,~~ *service that the facility has not provided in the previous 12 months, unless the medical care facility meets the criteria set forth in § 32.1-102.3:01, and (ii) any new cardiac catheterization, stereotactic radiosurgery, lithotripsy, medical rehabilitation, neonatal special care, obstetrical, open heart surgery, psychiatric, organ or tissue transplant service, radiation therapy, stereotactic radiotherapy, proton beam therapy service, or* substance abuse treatment *service*, or such other specialty clinical services as may be designated by the Board by regulation, ~~which~~ *that* the facility has ~~never provided or has~~ not provided in the previous 12 months;

6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds;

7. The addition by an existing medical care facility of any medical equipment for the provision of ~~cardiac catheterization,~~ *(i)* computed tomographic (CT) scanning~~, stereotactic radiosurgery, lithotripsy~~, magnetic resonance imaging (MRI), magnetic source imaging (MSI), ~~open heart surgery,~~ *or* positron emission tomographic (PET) scanning, *unless the medical care facility meets the criteria set forth in § 32.1-102.3:01, and (ii) cardiac catheterization, stereotactic radiosurgery, lithotripsy, open heart surgery,* radiation therapy, stereotactic radiotherapy, *or* proton beam therapy, or other specialized service designated by the Board by regulation. Replacement of existing equipment shall not require a certificate of public need;

8. Any capital expenditure of $15 million or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or on behalf of a medical care facility other than a general hospital. Capital expenditures of $5 million or more by a general hospital and capital expenditures between $5

and $15 million by a medical care facility other than a general hospital shall be registered with the Commissioner pursuant to regulations developed by the Board. The amounts specified in this subdivision shall be revised effective July 1, 2008, and annually thereafter to reflect inflation using appropriate measures incorporating construction costs and medical inflation. Nothing in this subdivision shall be construed to modify or eliminate the reviewability of any project described in subdivisions 1 through 7 of this definition when undertaken by or on behalf of a general hospital; or

9. Conversion in an existing medical care facility of psychiatric inpatient beds approved pursuant to a Request for Applications (RFA) to nonpsychiatric inpatient beds.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform the health planning activities set forth in this chapter within a health planning region.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services.

§ 32.1-102.1:1. Equipment registration required.

Within ~~thirty~~ *30* calendar days of becoming contractually obligated to acquire any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, *nuclear medicine imaging,* or other specialized service designated by the Board by regulation, ~~any~~ *such* person shall register such ~~purchase~~ *acquisition* with the Commissioner and the appropriate regional health planning agency.

§ 32.1-102.3:01. Exceptions.

A certificate shall not be required for projects involving (i) the introduction into an existing medical care facility of any new computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging service that the facility has not provided in the previous 12 months or (ii) the addition by an existing medical care facility of any medical equipment for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), or positron emission tomographic (PET) scanning if:

1. The medical care facility has obtained accreditation from the appropriate accrediting body for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging;

2. The medical care facility adheres to the American College of Radiology Appropriateness Criteria or other evidence-based national standards to discourage overutilization of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging;

3. All equipment used for imaging services, including computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging, meets current industry technology standards as determined by the Commissioner; and

4. The medical care facility agrees to provide computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging to indigent individuals in an amount that equals the average amount of imaging services, including computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging, provided to indigent individuals in accordance with the requirements of conditions on certificates of public need imposed pursuant to § 32.1-102.4 in the previous year in the health planning region in which the medical care facility is located.

Article 8.

Shared Savings for Imaging Services.

§ 38.2-3461. Definitions.

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

"Allowed amount" means the contractually agreed-upon amount paid or payable by a health carrier to a health care provider participating in the health carrier's network and the covered person's out-of-pocket costs.

"Average" means mean, median, or mode.

"Comparable imaging service" means nonemergency, outpatient imaging services, including computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI),

positron emission tomographic (PET) scanning, or nuclear medicine imaging, for which a carrier has not demonstrated that the allowed amount variation among participating providers is less than $50.

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

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of any comparable imaging service. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431. "Health benefit plan" does not include any health insurance plan administered by the Department of Human Resource Management, including the health coverage offered to state employees pursuant to § 2.2-2818; 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; health insurance coverage provided under the Line of Duty Act (§ 9.1-400 et seq.); or health insurance coverage provided by a multiple employer welfare arrangement.

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

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

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

"In-network provider" means a health care provider that has contracted with the health carrier, or with its contractor or subcontractor, to provide health care services to covered persons as a member of a network.

"Network" or "provider network" means the group of participating providers providing services to a health benefit plan under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of health care providers.

"Out-of-pocket costs" means any copayment, deductible, or coinsurance that is the responsibility of the covered person with respect to a covered health care service.

"Program" means the comparable health care service incentive program established by a health carrier pursuant to this article.

§ 38.2-3462. Comparable Imaging Service Incentive Program.

A. Beginning upon approval of the next insurance rate filing that follows January 1, 2020, each health carrier offering small group or large group health benefit plan coverage in the Commonwealth shall develop and implement a program that provides incentives for covered persons in its health benefit plan who elect to shop for low-cost, high quality in-network providers for comparable imaging services. Incentives may include cash payments to the covered person or a credit toward the covered person's annual in-network deductible and out-of-pocket limit. Health carriers may allow covered persons to select one or more incentives when multiple incentives are offered by the health carrier under the program.

B. Each health carrier shall make the program available as a component of all small group and large group health benefit plans offered by the health carrier in the Commonwealth. Annually at enrollment or renewal, each health carrier shall provide notice about the availability of the program, a description of the incentives available to a covered person, and instructions on how to earn such incentives, to any covered person who is enrolled in a health benefit plan eligible for the program.

C. Eligibility for an incentive payment may require a covered person to demonstrate, through reasonable documentation such as a quote from the health care provider, that the covered person shopped prior to receiving care from the health care provider. Health carriers shall provide additional mechanisms for the covered person to satisfy this requirement by utilizing the health carrier's cost transparency website or toll-free number, established under this article.

D. A comparable imaging service incentive payment made by a health carrier in accordance with this section shall not constitute an administrative expense of the health carrier for rate development or rate filing purposes.

E. Prior to offering the program to any covered person, a health carrier shall file a description of the program with the Commission in the manner determined by the Commission. The Commission may review the filing made by the health carrier to determine if the health carrier's program complies with the requirements of this article. Filings and any supporting documentation made pursuant to this subsection are confidential until the filing has been approved or denied by the Commission.

F. Annually each health carrier shall file with the Commission, for the most recent calendar year, the total number of comparable imaging service incentive payments made pursuant to this article and

the total number and percentage of a health carrier's covered persons that participated in such transactions.

G. Beginning no later than 18 months after implementation of comparable imaging service incentive programs under this section and annually by October 1 of each year thereafter, the Commission shall submit an aggregate report for all health carriers filing the information required by this section to the chairs of the House and Senate Committees on Commerce and Labor.

§ 38.2-3463. Health care price transparency tools.

Beginning upon approval of the next health insurance rate filing that follows January 1, 2020, each health carrier offering a health benefit plan in the Commonwealth shall comply with the following requirements:

1. A health carrier shall establish an interactive mechanism on its publicly accessible website that enables a covered person to request and obtain from the health carrier information on the expected member cost associated with in-network providers for comparable imaging services, as well as quality data for those providers, to the extent available. The interactive mechanism shall allow a covered person seeking information about the cost of a particular comparable imaging service to compare member out-of-pocket costs among in-network providers. The out-of-pocket estimate shall provide a good faith estimate of the amount the covered person will be responsible to pay out-of-pocket for a proposed comparable imaging service that is a medically necessary covered benefit from a health carrier's network provider based on the information available to the health carrier at the time the request is made. A health carrier may contract with a third-party vendor to satisfy the requirements of this subdivision.

2. Nothing in this section shall prohibit a health carrier from imposing cost-sharing requirements disclosed in the covered person's certificate of coverage for unforeseen health care services that arise out of the comparable imaging service or for a procedure or service provided to a covered person that was not included in an original estimate provided under subdivision 1.

3. A health carrier shall notify a covered person that an estimate provided under subdivision 1 is an estimate of costs and that the actual amount the covered person will be responsible to pay may vary due to the need for unforeseen services that arise out of the proposed comparable imaging service.

§ 38.2-3464. Rules and regulations; orders.

The Commission, after notice and opportunity for all interested parties to be heard, may issue any rules and regulations necessary or appropriate for the administration and enforcement of this article.

§ 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, *Article 8 (§ 38.2-3461 et seq.) of Chapter 34*, 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 shall apply to the operation of a plan.

§ 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.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 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, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 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, *Article 8 (§ 38.2-3461 et seq.) of*

Chapter 34, 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, 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.) 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.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 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.) 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.

§ 54.1-2910.01. Practitioner information provided to patients.

Upon request by a patient, doctors of medicine, osteopathy, and podiatry shall inform the patient about the following:

1. Procedures to access information on the doctor compiled by the Board of Medicine pursuant to § 54.1-2910.1; ~~and~~

2. If the patient is not covered by a health insurance plan that the doctor accepts or a managed care health insurance plan in which the doctor participates, the patient may be subject to the doctor's full charge which may be greater than the health plan's allowable charge*; and*

3. For purposes of § 38.2-3463, licensees of the Board of Medicine or their designee shall provide a description of the comparable imaging service, or the applicable standard procedural terminology or medical codes used by the American Medical Association, sufficient to allow a patient to compare care options if the patient is being referred for a comparable imaging service.