VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 2.1-342, 32.1-5, 32.1-122.10:01, 38.2-511, 38.2-4214, 38.2-4301, 38.2-4302, 38.2-4307, 38.2-4312, 38.2-4316, 38.2-4319, and 38.2-4509 of the Code of Virginia; to amend the Code of Virginia by adding in Chapter 5 of Title 32.1 articles numbered 1.1 and 1.2, consisting of sections numbered 32.1-137.1 through 32.1-137.6 and 32.1-137.7 through 32.1-137.17, respectively, and by adding in Title 38.2 a chapter numbered 58, consisting of sections numbered 38.2-5800 through 38.2-5811; and to repeal §§ 38.2-4308 and 38.2-4311 and Chapter 54 (§§ 38.2-5400 through 38.2-5409) of Title 38.2 of the Code of Virginia, relating to managed care health insurance plans; penalties.

[S 712]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-342, 32.1-5, 32.1-122.10:01, 38.2-511, 38.2-4214, 38.2-4301, 38.2-4302, 38.2-4307, 38.2-4312, 38.2-4316, 38.2-4319, and 38.2-4509 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 5 of Title 32.1 articles numbered 1.1 and 1.2, consisting of sections numbered 32.1-137.1 through 32.1-137.6 and 32.1-137.7 through 32.1-137.17, respectively, and by adding in Title 38.2 a chapter numbered 58, consisting of sections numbered 38.2-5800 through 38.2-5811, as follows:

§ 2.1-342. Official records to be open to inspection; procedure for requesting records and responding to request; charges; exceptions to application of chapter.

A. Except as otherwise specifically provided by law, all official records shall be open to inspection and copying by any citizens of the Commonwealth during the regular office hours of the custodian of such records. Access to such records shall not be denied to citizens of the Commonwealth, representatives of newspapers and magazines with circulation in the Commonwealth, and representatives of radio and television stations broadcasting in or into the Commonwealth. The custodian of such records shall take all necessary precautions for their preservation and safekeeping. Any public body covered under the provisions of this chapter shall make an initial response to citizens requesting records open to inspection within five work days after the receipt of the request by the public body which is the custodian of the requested records. Such citizen request shall designate the requested records with reasonable specificity. A specific reference to this chapter by the requesting citizen in his request shall not be necessary to invoke the provisions of this chapter and the time limits for response by the public body. The response by the public body within such five work days shall be one of the following responses:

1. The requested records shall be provided to the requesting citizen.

2. If the public body determines that an exemption applies to all of the requested records, it may refuse to release such records and provide to the requesting citizen a written explanation as to why the records are not available with the explanation making specific reference to the applicable Code sections which make the requested records exempt.

3. If the public body determines that an exemption applies to a portion of the requested records, it may delete or excise that portion of the records to which an exemption applies, but shall disclose the remainder of the requested records and provide to the requesting citizen a written explanation as to why these portions of the record are not available to the requesting citizen with the explanation making specific reference to the applicable Code sections which make that portion of the requested records exempt. Any reasonably segregatable portion of an official record shall be provided to any person requesting the record after the deletion of the exempt portion.

4. If the public body determines that it is practically impossible to provide the requested records or to determine whether they are available within the five-work-day period, the public body shall so inform the requesting citizen and shall have an additional seven work days in which to provide one of the three preceding responses.

Nothing in this section shall prohibit any public body from petitioning the appropriate court for additional time to respond to a request for records when the request is for an extraordinary volume of records and a response by the public body within the time required by this chapter will prevent the public body from meeting its operational responsibilities. Before proceeding with this petition, however, the public body shall make reasonable efforts to reach an agreement with the requester concerning the production of the records requested.

The public body may make reasonable charges for the copying, search time and computer time

expended in the supplying of such records. The public body may also make a reasonable charge for preparing documents produced from a geographic information system at the request of anyone other than the owner of the land that is the subject of the request. However, such charges shall not exceed the actual cost to the public body in supplying such records or documents, except that the public body may charge, on a pro rata per acre basis, for the cost of creating topographical maps developed by the public body, for such maps or portions thereof, which encompass a contiguous area greater than fifty acres. Such charges for the supplying of requested records shall be estimated in advance at the request of the citizen. The public body may require the advance payment of charges which are subject to advance determination.

In any case where a public body determines in advance that search and copying charges for producing the requested documents are likely to exceed $200, the public body may, before continuing to process the request, require the citizen requesting the information to agree to payment of an amount not to exceed the advance determination by five percent. The period within which the public body must respond under this section shall be tolled for the amount of time that elapses between notice of the advance determination and the response of the citizen requesting the information.

Official records maintained by a public body on a computer or other electronic data processing system which are available to the public under the provisions of this chapter shall be made reasonably accessible to the public at reasonable cost. Beginning July 1, 1997, every public body of state government shall compile, and annually update, an index of computer databases which contains at a minimum those databases created by them on or after July 1, 1997. "Computer database" means a structured collection of data or documents residing in a computer. Such index shall be an official record and shall include, at a minimum, the following information with respect to each database listed therein: a list of data fields, a description of the format or record layout, the date last updated, a list of any data fields to which public access is restricted, a description of each format in which the database can be copied or reproduced using the public body's computer facilities, and a schedule of fees for the production of copies in each available form. The form, context, language, and guidelines for the indices and the databases to be indexed shall be developed by the Director of the Department of Information Technology in consultation with the State Librarian and the State Archivist. The public body shall not be required to disclose its software security, including passwords.

Public bodies shall not be required to create or prepare a particular requested record if it does not already exist. Public bodies may, but shall not be required to, abstract or summarize information from official records or convert an official record available in one form into another form at the request of the citizen. The public body shall make reasonable efforts to reach an agreement with the requester concerning the production of the records requested.

Failure to make any response to a request for records shall be a violation of this chapter and deemed a denial of the request.

B. The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Memoranda, correspondence, evidence and complaints related to criminal investigations; adult arrestee photographs when necessary to avoid jeopardizing an investigation in felony cases until such time as the release of such photograph will no longer jeopardize the investigation; reports submitted to the state and local police, to investigators authorized pursuant to § 53.1-16 and to the campus police departments of public institutions of higher education as established by Chapter 17 (§ 23-232 et seq.) of Title 23 in confidence; portions of records of local government crime commissions that would identify individuals providing information about crimes or criminal activities under a promise of anonymity; records of local police departments relating to neighborhood watch programs that include the names, addresses, and operating schedules of individual participants in the program that are provided to such departments under a promise of confidentiality; and all records of persons imprisoned in penal institutions in the Commonwealth provided such records relate to the imprisonment. Information in the custody of law-enforcement officials relative to the identity of any individual other than a juvenile who is arrested and charged, and the status of the charge or arrest, shall not be excluded from the provisions of this chapter.

Criminal incident information relating to felony offenses shall not be excluded from the provisions of this chapter; however, where the release of criminal incident information is likely to jeopardize an ongoing criminal investigation or the safety of an individual, cause a suspect to flee or evade detection, or result in the destruction of evidence, such information may be withheld until the above-referenced damage is no longer likely to occur from release of the information.

2. Confidential records of all investigations of applications for licenses and permits, and all licensees and permittees made by or submitted to the Alcoholic Beverage Control Board, the State Lottery Department, the Virginia Racing Commission, or the Charitable Gaming Commission.

3. State income, business, and estate tax returns, personal property tax returns, scholastic records and

personnel records containing information concerning identifiable individuals, except that such access shall not be denied to the person who is the subject thereof, and medical and mental records, except that such records can be personally reviewed by the subject person or a physician of the subject person's choice; however, the subject person's mental records may not be personally reviewed by such person when the subject person's treating physician has made a part of such person's records a written statement that in his opinion a review of such records by the subject person would be injurious to the subject person's physical or mental health or well-being.

Where the person who is the subject of medical records is confined in a state or local correctional facility, the administrator or chief medical officer of such facility may assert such confined person's right of access to the medical records if the administrator or chief medical officer has reasonable cause to believe that such confined person has an infectious disease or other medical condition from which other persons so confined need to be protected. Medical records shall be reviewed only and shall not be copied by such administrator or chief medical officer. The information in the medical records of a person so confined shall continue to be confidential and shall not be disclosed to any person except the subject by the administrator or chief medical officer of the facility or except as provided by law.

For the purposes of this chapter such statistical summaries of incidents and statistical data concerning patient abuse as may be compiled by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall be open to inspection and releasable as provided in subsection A of this section. No such summaries or data shall include any patient-identifying information. Where the person who is the subject of scholastic or medical and mental records is under the age of eighteen, his right of access may be asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental rights have been terminated or a court of competent jurisdiction has restricted or denied such access. In instances where the person who is the subject thereof is an emancipated minor or a student in a state-supported institution of higher education, such right of access may be asserted by the subject person.

4. Memoranda, working papers and correspondence (i) held by or requested from members of the General Assembly or the Division of Legislative Services or (ii) held or requested by the Office of the Governor or Lieutenant Governor, Attorney General or the mayor or other chief executive officer of any political subdivision of the Commonwealth or the president or other chief executive officer of any state-supported institution of higher education. This exclusion shall not apply to memoranda, studies or other papers held or requested by the mayor or other chief executive officer of any political subdivision which are specifically concerned with the evaluation of performance of the duties and functions of any locally elected official and were prepared after June 30, 1992, nor shall this exclusion apply to agenda packets prepared and distributed to public bodies for use at a meeting.

Except as provided in § 30-28.18, memoranda, working papers and correspondence of a member of the General Assembly held by the Division of Legislative Services shall not be released by the Division without the prior consent of the member.

5. Written opinions of the city, county and town attorneys of the cities, counties and towns in the Commonwealth and any other writing protected by the attorney-client privilege.

6. Memoranda, working papers and records compiled specifically for use in litigation or as a part of an active administrative investigation concerning a matter which is properly the subject of an executive or closed meeting under § 2.1-344 and material furnished in confidence with respect thereto.

7. Confidential letters and statements of recommendation placed in the records of educational agencies or institutions respecting (i) admission to any educational agency or institution, (ii) an application for employment, or (iii) receipt of an honor or honorary recognition.

8. Library records which can be used to identify both (i) any library patron who has borrowed material from a library and (ii) the material such patron borrowed.

9. Any test or examination used, administered or prepared by any public body for purposes of evaluation of (i) any student or any student's performance, (ii) any employee or employment seeker's qualifications or aptitude for employment, retention, or promotion, or (iii) qualifications for any license or certificate issued by any public body.

As used in this subdivision 9, "test or examination" shall include (i) any scoring key for any such test or examination and (ii) any other document which would jeopardize the security of such test or examination. Nothing contained in this subdivision 9 shall prohibit the release of test scores or results as provided by law, or limit access to individual records as is provided by law. However, the subject of such employment tests shall be entitled to review and inspect all documents relative to his performance on such employment tests.

When, in the reasonable opinion of such public body, any such test or examination no longer has any potential for future use, and the security of future tests or examinations will not be jeopardized, such test or examination shall be made available to the public. However, minimum competency tests administered to public school children shall be made available to the public contemporaneously with statewide release

of the scores of those taking such tests, but in no event shall such tests be made available to the public later than six months after the administration of such tests.

10. Applications for admission to examinations or for licensure and scoring records maintained by the Department of Health Professions or any board in that department on individual licensees or applicants. However, such material may be made available during normal working hours for copying, at the requester's expense, by the individual who is the subject thereof, in the offices of the Department of Health Professions or in the offices of any health regulatory board, whichever may possess the material.

11. Records of active investigations being conducted by the Department of Health Professions or by any health regulatory board in the Commonwealth.

12. Memoranda, legal opinions, working papers and records recorded in or compiled exclusively for executive or closed meetings lawfully held pursuant to § 2.1-344.

13. Reports, documentary evidence and other information as specified in §§ 2.1-373.2 and 63.1-55.4.

14. Proprietary information gathered by or for the Virginia Port Authority as provided in § 62.1-132.4 or § 62.1-134.1.

15. Contract cost estimates prepared for the confidential use of the Department of Transportation in awarding contracts for construction or the purchase of goods or services and records, documents and automated systems prepared for the Department's Bid Analysis and Monitoring Program.

16. Vendor proprietary information software which may be in the official records of a public body. For the purpose of this section, "vendor proprietary software" means computer programs acquired from a vendor for purposes of processing data for agencies or political subdivisions of the Commonwealth.

17. Data, records or information of a proprietary nature produced or collected by or for faculty or staff of state institutions of higher learning, other than the institutions' financial or administrative records, in the conduct of or as a result of study or research on medical, scientific, technical or scholarly issues, whether sponsored by the institution alone or in conjunction with a governmental body or a private concern, where such data, records or information has not been publicly released, published, copyrighted or patented.

18. Financial statements not publicly available filed with applications for industrial development financings.

19. Lists of registered owners of bonds issued by a political subdivision of the Commonwealth, whether the lists are maintained by the political subdivision itself or by a single fiduciary designated by the political subdivision.

20. Confidential proprietary records, voluntarily provided by private business pursuant to a promise of confidentiality from the Department of Business Assistance, the Virginia Economic Development Partnership or local or regional industrial or economic development authorities or organizations, used by the Department, the Partnership, or such entities for business, trade and tourism development; and memoranda, working papers or other records related to businesses that are considering locating or expanding in Virginia, prepared by the Partnership, where competition or bargaining is involved and where, if such records are made public, the financial interest of the governmental unit would be adversely affected.

21. Information which was filed as confidential under the Toxic Substances Information Act (§ 32.1-239 et seq.), as such Act existed prior to July 1, 1992.

22. Documents as specified in § 58.1-3.

23. Confidential records, including victim identity, provided to or obtained by staff in a rape crisis center or a program for battered spouses.

24. Computer software developed by or for a state agency, state-supported institution of higher education or political subdivision of the Commonwealth.

25. Investigator notes, and other correspondence and information, furnished in confidence with respect to an active investigation of individual employment discrimination complaints made to the Department of Personnel and Training; however, nothing in this section shall prohibit the disclosure of information taken from inactive reports in a form which does not reveal the identity of charging parties, persons supplying the information or other individuals involved in the investigation.

26. Fisheries data which would permit identification of any person or vessel, except when required by court order as specified in § 28.2-204.

27. Records of active investigations being conducted by the Department of Medical Assistance Services pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1.

28. Documents and writings furnished by a member of the General Assembly to a meeting of a standing committee, special committee or subcommittee of his house established solely for the purpose of reviewing members' annual disclosure statements and supporting materials filed under § 2.1-639.40 or of formulating advisory opinions to members on standards of conduct, or both.

29. Customer account information of a public utility affiliated with a political subdivision of the Commonwealth, including the customer's name and service address, but excluding the amount of utility

service provided and the amount of money paid for such utility service.

30. Investigative notes and other correspondence and information furnished in confidence with respect to an investigation or conciliation process involving an alleged unlawful discriminatory practice under the Virginia Human Rights Act (§ 2.1-714 et seq.); however, nothing in this section shall prohibit the distribution of information taken from inactive reports in a form which does not reveal the identity of the parties involved or other persons supplying information.

31. Investigative notes; proprietary information not published, copyrighted or patented; information obtained from employee personnel records; personally identifiable information regarding residents, clients or other recipients of services; and other correspondence and information furnished in confidence to the Department of Social Services in connection with an active investigation of an applicant or licensee pursuant to Chapters 9 (§ 63.1-172 et seq.) and 10 (§ 63.1-195 et seq.) of Title 63.1; however, nothing in this section shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information, or other individuals involved in the investigation.

32. Reports, manuals, specifications, documents, minutes or recordings of staff meetings or other information or materials of the Virginia Board of Corrections, the Virginia Department of Corrections or any institution thereof to the extent, as determined by the Director of the Department of Corrections or his designee or of the Virginia Board of Juvenile Justice, the Virginia Department of Juvenile Justice or any facility thereof to the extent as determined by the Director of the Department of Juvenile Justice, or his designee, that disclosure or public dissemination of such materials would jeopardize the security of any correctional or juvenile facility or institution, as follows:

(i) Security manuals, including emergency plans that are a part thereof;

(ii) Engineering and architectural drawings of correctional and juvenile facilities, and operational specifications of security systems utilized by the Departments, provided the general descriptions of such security systems, cost and quality shall be made available to the public;

(iii) Training manuals designed for correctional and juvenile facilities to the extent that they address procedures for institutional security, emergency plans and security equipment;

(iv) Internal security audits of correctional and juvenile facilities, but only to the extent that they specifically disclose matters described in (i), (ii), or (iii) above or other specific operational details the disclosure of which would jeopardize the security of a correctional or juvenile facility or institution;

(v) Minutes or recordings of divisional, regional and institutional staff meetings or portions thereof to the extent that such minutes deal with security issues listed in (i), (ii), (iii), and (iv) of this subdivision;

(vi) Investigative case files by investigators authorized pursuant to § 53.1-16; however, nothing in this section shall prohibit the disclosure of information taken from inactive reports in a form which does not reveal the identity of complainants or charging parties, persons supplying information, confidential sources, or other individuals involved in the investigation, or other specific operational details the disclosure of which would jeopardize the security of a correctional or juvenile facility or institution; nothing herein shall permit the disclosure of materials otherwise exempt as set forth in subdivision 1 of subsection B of this section;

(vii) Logs or other documents containing information on movement of inmates, juvenile clients or employees; and

(viii) Documents disclosing contacts between inmates, juvenile clients and law-enforcement personnel.

Notwithstanding the provisions of this subdivision, reports and information regarding the general operations of the Departments, including notice that an escape has occurred, shall be open to inspection and copying as provided in this section.

33. Personal information, as defined in § 2.1-379, (i) filed with the Virginia Housing Development Authority concerning individuals who have applied for or received loans or other housing assistance or who have applied for occupancy of or have occupied housing financed, owned or otherwise assisted by the Virginia Housing Development Authority, (ii) concerning persons participating in or persons on the waiting list for federally funded rent-assistance programs, or (iii) filed with any local redevelopment and housing authority created pursuant to § 36-4 concerning persons participating in or persons on the waiting list for housing assistance programs funded by local governments or by any such authority. However, access to one's own information shall not be denied.

34. Documents regarding the siting of hazardous waste facilities, except as provided in § 10.1-1441, if disclosure of them would have a detrimental effect upon the negotiating position of a governing body or on the establishment of the terms, conditions and provisions of the siting agreement.

35. Appraisals and cost estimates of real property subject to a proposed purchase, sale or lease, prior to the completion of such purchase, sale or lease.

36. Records containing information on the site specific location of rare, threatened, endangered or otherwise imperiled plant and animal species, natural communities, caves, and significant historic and

archaeological sites if, in the opinion of the public body which has the responsibility for such information, disclosure of the information would jeopardize the continued existence or the integrity of the resource. This exemption shall not apply to requests from the owner of the land upon which the resource is located.

37. Official records, memoranda, working papers, graphics, video or audio tapes, production models, data and information of a proprietary nature produced by or for or collected by or for the State Lottery Department relating to matters of a specific lottery game design, development, production, operation, ticket price, prize structure, manner of selecting the winning ticket, manner of payment of prizes to holders of winning tickets, frequency of drawings or selections of winning tickets, odds of winning, advertising, or marketing, where such official records have not been publicly released, published, copyrighted or patented. Whether released, published or copyrighted, all game-related information shall be subject to public disclosure under this chapter upon the first day of sales for the specific lottery game to which it pertains.

38. Official records of studies and investigations by the State Lottery Department of (i) lottery agents, (ii) lottery vendors, (iii) lottery crimes under §§ 58.1-4014 through 58.1-4018, (iv) defects in the law or regulations which cause abuses in the administration and operation of the lottery and any evasions of such provisions, or (v) use of the lottery as a subterfuge for organized crime and illegal gambling where such official records have not been publicly released, published or copyrighted. All studies and investigations referred to under ~~subdivisions~~ *clauses* (iii), (iv) and (v) shall be subject to public disclosure under this chapter upon completion of the study or investigation.

39. Those portions of engineering and construction drawings and plans submitted for the sole purpose of complying with the building code in obtaining a building permit which would identify specific trade secrets or other information the disclosure of which would be harmful to the competitive position of the owner or lessee; however, such information shall be exempt only until the building is completed. Information relating to the safety or environmental soundness of any building shall not be exempt from disclosure.

40. [Repealed.]

41. Records concerning reserves established in specific claims administered by the Department of General Services through its Division of Risk Management as provided in Article 5.1 (§ 2.1-526.1 et seq.) of Chapter 32 of this title, or by any county, city, or town.

42. Information and records collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Services System and Services pursuant to Article 2.1 (§ 32.1-111.1 et seq.) of Title 32.1.

43. Reports and court documents required to be kept confidential pursuant to § 37.1-67.3.

44. [Repealed.]

45. Investigative notes; correspondence and information furnished in confidence with respect to an investigation; and official records otherwise exempted by this chapter or any Virginia statute, provided to or produced by or for the Auditor of Public Accounts and the Joint Legislative Audit and Review Commission; or investigative notes, correspondence, documentation and information furnished and provided to or produced by or for the Department of the State Internal Auditor with respect to an investigation initiated through the State Employee Fraud, Waste and Abuse Hotline. Nothing in this chapter shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information or other individuals involved in the investigation; however, disclosure, unless such disclosure is prohibited by this section, of information from the records of completed investigations shall include, but is not limited to, the agency involved, the identity of the person who is the subject of the complaint, the nature of the complaint, and the actions taken to resolve the complaint. In the event an investigation does not lead to corrective action, the identity of the person who is the subject of the complaint may be released only with the consent of the subject person.

46. Data formerly required to be submitted to the Commissioner of Health relating to the establishment of new or expansion of existing clinical health services, acquisition of major medical equipment, or certain projects requiring capital expenditures pursuant to former § 32.1-102.3:4.

47. Documentation or other information which describes the design, function, operation or access control features of any security system, whether manual or automated, which is used to control access to or use of any automated data processing or telecommunications system.

48. Confidential financial statements, balance sheets, trade secrets, and revenue and cost projections provided to the Department of Rail and Public Transportation, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Interstate Commerce Commission or the Federal Rail Administration with respect to data provided in confidence to the Interstate Commerce Commission and the Federal Railroad Administration.

49. In the case of corporations organized by the Virginia Retirement System, (i) proprietary information provided by, and financial information concerning, coventurers, partners, lessors, lessees, or investors, and (ii) records concerning the condition, acquisition, disposition, use, leasing, development, coventuring, or management of real estate the disclosure of which would have a substantial adverse impact on the value of such real estate or result in a competitive disadvantage to the corporation or subsidiary.

50. Confidential proprietary records related to inventory and sales, voluntarily provided by private energy suppliers to the Department of Mines, Minerals and Energy, used by that Department for energy contingency planning purposes or for developing consolidated statistical information on energy supplies.

51. Confidential proprietary information furnished to the Board of Medical Assistance Services or the Medicaid Prior Authorization Advisory Committee pursuant to Article 4 (§ 32.1-331.12 et seq.) of Chapter 10 of Title 32.1.

52. [Repealed.]

53. Proprietary, commercial or financial information, balance sheets, trade secrets, and revenue and cost projections provided by a private transportation business to the Virginia Department of Transportation and the Department of Rail and Public Transportation for the purpose of conducting transportation studies needed to obtain grants or other financial assistance under the Intermodal Surface Transportation Efficiency Act of 1991 (P.L. 102-240) for transportation projects, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Interstate Commerce Commission or the Federal Rail Administration with respect to data provided in confidence to the Interstate Commerce Commission and the Federal Railroad Administration. However, the exemption provided by this subdivision shall not apply to any wholly owned subsidiary of a public body.

54. Names and addresses of subscribers to Virginia Wildlife magazine, published by the Department of Game and Inland Fisheries, provided the individual subscriber has requested in writing that the Department not release such information.

55. Reports, documents, memoranda or other information or materials which describe any aspect of security used by the Virginia Museum of Fine Arts to the extent that disclosure or public dissemination of such materials would jeopardize the security of the Museum or any warehouse controlled by the Museum, as follows:

a. Operational, procedural or tactical planning documents, including any training manuals to the extent they discuss security measures;

b. Surveillance techniques;

c. Installation, operation, or utilization of any alarm technology;

d. Engineering and architectural drawings of the Museum or any warehouse;

e. Transportation of the Museum's collections, including routes and schedules; or

f. Operation of the Museum or any warehouse used by the Museum involving the:

(1) Number of employees, including security guards, present at any time; or

(2) Busiest hours, with the maximum number of visitors in the Museum.

56. Reports, documents, memoranda or other information or materials which describe any aspect of security used by the Virginia Department of Alcoholic Beverage Control to the extent that disclosure or public dissemination of such materials would jeopardize the security of any government store as defined in Title 4.1, or warehouse controlled by the Department of Alcoholic Beverage Control, as follows:

(i) Operational, procedural or tactical planning documents, including any training manuals to the extent they discuss security measures;

(ii) Surveillance techniques;

(iii) The installation, operation, or utilization of any alarm technology;

(iv) Engineering and architectural drawings of such government stores or warehouses;

(v) The transportation of merchandise, including routes and schedules; and

(vi) The operation of any government store or the central warehouse used by the Department of Alcoholic Beverage Control involving the:

a. Number of employees present during each shift;

b. Busiest hours, with the maximum number of customers in such government store; and

c. Banking system used, including time and place of deposits.

57. Information required to be provided pursuant to § 54.1-2506.1.

58. Confidential information designated as provided in subsection D of § 11-52 as trade secrets or proprietary information by any person who has submitted to a public body an application for prequalification to bid on public construction projects in accordance with subsection B of § 11-46.

59. All information and records acquired during a review of any child death by the State Child Fatality Review Team established pursuant to § 32.1-283.1.

60. Investigative notes, correspondence, documentation and information provided to or produced by

or for the committee or the auditor with respect to an investigation or audit conducted pursuant to § 15.1-765.2. Nothing in this section shall prohibit disclosure of information from the records of completed investigations or audits in a form that does not reveal the identity of complainants or persons supplying information.

61. Financial, medical, rehabilitative and other personal information concerning applicants for or recipients of loan funds submitted to or maintained by the Assistive Technology Loan Fund Authority under Chapter 11 (§ 51.5-53 et seq.) of Title 51.5.

62. Confidential proprietary records which are voluntarily provided by a private entity pursuant to a proposal filed with a public entity under the Public-Private Transportation Act of 1995 (§ 56-556 et seq.), pursuant to a promise of confidentiality from the responsible public entity, used by the responsible public entity for purposes related to the development of a qualifying transportation facility; and memoranda, working papers or other records related to proposals filed under the Public-Private Transportation Act of 1995, where, if such records were made public, the financial interest of the public or private entity involved with such proposal or the process of competition or bargaining would be adversely affected. In order for confidential proprietary information to be excluded from the provisions of this chapter, the private entity shall (i) invoke such exclusion upon submission of the data or other materials for which protection from disclosure is sought, (ii) identify the data or other materials for which protection is sought, and (iii) state the reasons why protection is necessary. For the purposes of this subdivision, the terms public entity and private entity shall be defined as they are defined in the Public-Private Transportation Act of 1995.

63. Records of law-enforcement agencies, to the extent that such records contain specific tactical plans, the disclosure of which would jeopardize the safety or security of law-enforcement personnel or the general public; engineering plans, architectural drawings, or operational specifications of governmental law-enforcement facilities, including but not limited to courthouses, jails, and detention facilities, to the extent that disclosure could jeopardize the safety or security of law-enforcement offices; however, general descriptions shall be provided to the public upon request.

64. All records of the University of Virginia or the University of Virginia Medical Center which contain proprietary, business-related information pertaining to the operations of the University of Virginia Medical Center, including its business development or marketing strategies and its activities with existing or future joint venturers, partners, or other parties with whom the University of Virginia Medical Center has formed, or forms, any arrangement for the delivery of health care, if disclosure of such information would be harmful to the competitive position of the Medical Center.

65. Patient level data collected by the Board of Health and not yet processed, verified, and released, pursuant to § 32.1-276.9, to the Board by the nonprofit organization with which the Commissioner of Health has contracted pursuant to § 32.1-276.4.

66. Records of the Medical College of Virginia Hospitals Authority pertaining to any of the following: (i) an individual's qualifications for or continued membership on its medical or teaching staffs; proprietary information gathered by or in the possession of the Authority from third parties pursuant to a promise of confidentiality; contract cost estimates prepared for confidential use in awarding contracts for construction or the purchase of goods or services; data, records or information of a proprietary nature produced or collected by or for the Authority or members of its medical or teaching staffs; financial statements not publicly available that may be filed with the Authority from third parties; the identity, accounts or account status of any customer of the Authority; consulting or other reports paid for by the Authority to assist the Authority in connection with its strategic planning and goals; and the determination of marketing and operational strategies where disclosure of such strategies would be harmful to the competitive position of the Authority; and (ii) data, records or information of a proprietary nature produced or collected by or for employees of the Authority, other than the Authority's financial or administrative records, in the conduct of or as a result of study or research on medical, scientific, technical or scholarly issues, whether sponsored by the Authority alone or in conjunction with a governmental body or a private concern, when such data, records or information have not been publicly released, published, copyrighted or patented.

67. Confidential proprietary information or trade secrets, not publicly available, provided by a private person or entity to the Virginia Resources Authority or to a fund administered in connection with financial assistance rendered or to be rendered by the Virginia Resources Authority where, if such information is made public, the financial interest of the private person or entity would be adversely affected, and, after June 30, 1997, where such information was provided pursuant to a promise of confidentiality.

68. Confidential proprietary records which are provided by a franchisee under § 15.1-23.1 to its franchising authority pursuant to a promise of confidentiality from the franchising authority which relates to the franchisee's potential provision of new services, adoption of new technologies or implementation of improvements, where such new services, technologies or improvements have not been

implemented by the franchisee on a nonexperimental scale in the franchise area, and where, if such records were made public, the competitive advantage or financial interests of the franchisee would be adversely affected. In order for confidential proprietary information to be excluded from the provisions of this chapter, the franchisee shall (i) invoke such exclusion upon submission of the data or other materials for which protection from disclosure is sought, (ii) identify the data or other materials for which protection is sought, and (iii) state the reason why protection is necessary.

69. Records of the Intervention Program Committee within the Department of Health Professions to the extent such records may identify any practitioner who may be, or who is actually, impaired to the extent disclosure is prohibited by § 54.1-2517.

70. Records submitted as a grant application, or accompanying a grant application, to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Article 12 (§ 32.1-73.1 et seq.) of Chapter 2 of Title 32.1, to the extent such records contain: (i) medical or mental records, or other data identifying individual patients, or (ii) proprietary business or research related information produced or collected by the applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical or scholarly issues, when such information has not been publicly released, published, copyrighted or patented, if the disclosure of such information would be harmful to the competitive position of the applicant.

71. Information which would disclose the security aspects of a system safety program plan adopted pursuant to 49 C.F.R. Part 659 by the Commonwealth's designated Rail Fixed Guideway Systems Safety Oversight agency; and information in the possession of such agency the release of which would jeopardize the success of an ongoing investigation of a rail accident or other incident threatening railway safety.

72. Documents and other information of a proprietary nature furnished by a supplier of charitable gaming supplies to the Charitable Gaming Commission pursuant to subsection E of § 18.2-340.34.

73. Personal information, as defined in § 2.1-379, provided to the Board of the Virginia Higher Education Tuition Trust Fund or its employees by or on behalf of individuals who have requested information about, applied for, or entered into prepaid tuition contracts pursuant to Chapter 4.9 (§ 23-38.75 et seq.) of Title 23. Nothing in this subdivision shall be construed to prohibit disclosure or publication of information in a statistical or other form which does not identify individuals or provide personal information. Individuals shall be provided access to their own personal information.

74. Any record copied, recorded or received by the Commissioner of Health in the course of an examination, investigation or review of a managed care health insurance plan licensee pursuant to §§ 32.1-137.4 and 32.1-137.5, including books, records, files, accounts, papers, documents, and any or all computer or other recordings.

C. Neither any provision of this chapter nor any provision of Chapter 26 (§ 2.1-377 et seq.) of this title shall be construed as denying public access to contracts between a public official and a public body, other than contracts settling public employee employment disputes held confidential as personnel records under subdivision 3 of subsection B of this section, or to records of the position, job classification, official salary or rate of pay of, and to records of the allowances or reimbursements for expenses paid to, any public officer, official or employee at any level of state, local or regional government in the Commonwealth or to the compensation or benefits paid by any corporation organized by the Virginia Retirement System or its officers or employees. The provisions of this subsection, however, shall not apply to records of the official salaries or rates of pay of public employees whose annual rate of pay is $10,000 or less.

D. No provision of this chapter shall be construed to afford any rights to any person incarcerated in a state, local or federal correctional facility, whether or not such facility is (i) located in the Commonwealth or (ii) operated pursuant to the Corrections Private Management Act (§ 53.1-261 et seq.). However, this subsection shall not be construed to prevent an incarcerated person from exercising his constitutionally protected rights, including but not limited to his rights to call for evidence in his favor in a criminal prosecution.

§ 32.1-5. Appointment of members; terms and vacancies.

There shall be a State Board of Health which shall consist of ~~eleven~~ *thirteen* residents of the Commonwealth appointed by the Governor for terms of four years each. Two members of the Board shall be members of the Medical Society of Virginia, one member shall be a member of the Virginia Pharmaceutical Association, one member shall be a member of the State Dental Association, one member shall be a member of the Virginia Nurses' Association, one member shall be a member of the Virginia Veterinary Medical Association, one member shall be a representative of local government, one member shall be a representative of the hospital industry, one member shall be a representative of the nursing home industry, *one member shall be a representative of the licensed health carriers responsible under Title 38.2 for a managed care health insurance plan, one member shall be a corporate purchaser of health care,* and two members shall be consumers. A vacancy other than by expiration of term shall

be filled by the Governor for the unexpired term.

No person shall be eligible to serve more than two full consecutive four-year terms.

§ 32.1-122.10:01. Review of health maintenance organizations.

A. The State Health Commissioner (the "Commissioner") shall examine the quality of health care services of any health maintenance organization ("HMO") licensed in Virginia pursuant to §§ 38.2-4301 and 38.2-4302 and, *at the Commissioner's discretion,* the providers with whom the organization has contracts, agreements, or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth. The Commissioner shall consult with HMOs and providers in carrying out his duties under this section.

B. For the purposes of examinations, the Commissioner may review records, take affidavits, and interview the officers and agents of the HMO and the principals of the providers concerning their business.

C. The expenses of examinations by or for the Commissioner under this section shall be assessed against the organization being examined and remitted to the Commissioner.

D. In making his examination, the Commissioner may consider the report of an examination of a foreign HMO certified by the insurance supervisory official, a similar regulatory agency, an independent recognized accrediting organization, or the state health commissioner of another state.

E. The Commissioner also shall: (i) consult with HMOs in the establishment of their complaint systems as provided in § ~~38.2-4308~~ *38.2-5804*; (ii) review and analyze HMOs' complaint reports which are required in subsection B of § ~~38.2-4308~~ *38.2-5804*; and (iii) assist the State Corporation Commission in examining such complaint systems, as provided in subsection C of § ~~38.2-4308~~ *38.2-5804*.

F. The Commissioner shall coordinate the activities undertaken pursuant to this section with the State Corporation Commission to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

G. This section shall expire upon the earlier of (i) promulgation and final adoption of regulations governing certification of quality assurance for managed care health insurance plan licensees pursuant to Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 of this title or (ii) July 1, 2000.

Article 1.1.

Certificate of Quality Assurance of Managed Care Health Insurance Plan Licensees.

§ 32.1-137.1. Definitions.

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

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

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

"Complaint" means any written communication from a covered person primarily expressing a grievance.

"Covered person" means an individual residing in the Commonwealth, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan under Title 38.2.

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

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

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

§ 32.1-137.2. 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 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.

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.

§ 32.1-137.3. Regulations.

Consistent with its duties to protect the health, safety, and welfare of the public, the Board shall promulgate regulations, consistent with this article, governing the quality of care provided to covered persons by a managed care health insurance plan licensee through its managed care health insurance plans on or before December 1, 1999. The regulations may incorporate or apply nationally recognized, generally accepted, quality standards developed by private accreditation entities, if such standards exist and as appropriate for the type of managed care health insurance plan. The regulations shall also include guidelines for the Commissioner to determine, in consultation with the Bureau of Insurance, when the imposition of administrative sanctions as set forth in § 32.1-137.5 or initiation of court proceedings or both are appropriate in order to ensure prompt correction of violations discovered on any examination, review, or investigation conducted by the Department pursuant to provisions of this article.

§ 32.1-137.4. Examination, review or investigation.

A. The Commissioner shall cause each managed care health insurance plan licensee subject to certification under this article to be examined or reviewed for each new application and to be periodically examined or reviewed at reasonable times thereafter, including both for complaint investigation and for renewal compliance. Such examinations or reviews shall consider the compliance of the managed care health insurance plan licensee with the regulations promulgated under § 32.1-137.3.

In lieu of or in addition to making his own examination of the managed care health insurance plan licensee, the Commissioner may accept the report of an examination of the licensee under similar laws of another state, similar regulatory agency, state health commissioner, or accreditation entity.

B. Any examiner authorized by the Commissioner shall, so far as necessary for the purposes of the examination or review, have access during regular business hours to the premises and to any books, records, files, or property of the licensee as far as they directly relate to the quality of care provided by the licensee. All material copied or recorded or received shall be privileged and confidential and shall not be subject to subpoena.

C. Every person from whom information is sought, in an investigation of a complaint pursuant to this article against a managed care health insurance plan licensee, shall cooperate in producing or allowing reasonable access during regular business hours to the books, records, files, accounts, papers, documents, and any or all computer or other recordings of the licensee being examined or those of any person delivering health care services under contract, affiliation, delegation or other arrangement directly relevant to the investigation. Such information shall be limited to that which is relevant to the investigation in question, as specified in regulations promulgated pursuant to this article. All material copied or recorded or received shall be privileged and confidential, and shall not be subject to subpoena.

D. The refusal of any licensee, by its officers, directors, employees or agents, to submit to examination or review or to comply with any reasonable written request of the examiners shall be grounds for suspension, revocation, denial, or nonrenewal of any certificate of quality assurance held by the licensee. Any such proceedings for suspension, revocation, denial or nonrenewal of any certificate shall be conducted pursuant to § 32.1-137.5.

§ 32.1-137.5. Civil penalties; probation, suspension, restriction or prohibition of new enrollments to managed care health insurance plan licensee; revocation or nonrenewal of certificate of quality assurance; appeal process; correction.

A. In accordance with applicable regulations of the Board and in consultation with the Bureau of Insurance, the Commissioner (i) may impose civil penalties, which shall not exceed $1,000 per incident of noncompliance, to a maximum of $10,000 for a series of related incidents of noncompliance, (ii) may place a certificate holder on probation, (iii) may temporarily suspend a certificate of quality assurance of a managed care health insurance plan licensee, (iv) may, with the concurrence of the Bureau of Insurance, temporarily restrict or prohibit new enrollments into a managed care health insurance plan, or (v) may revoke or not renew a certificate of quality assurance and certify to the State Corporation Commission that a managed care health insurance plan licensee or its managed care health insurance plan is unable to fulfill its obligations to furnish quality health care services as set forth in this article. Fines payable under this section shall be paid into the Literary Fund.

B. When examination or review or complaint investigation by the Department results in a finding of

noncompliance with the provisions of this article or the regulations of the Board, the managed care health insurance plan licensee or applicant shall be provided written notice and a report specifying the findings of noncompliance and providing an opportunity to be heard in no fewer than thirty days by the Commissioner's adjudication officer in a proceeding under § 9-6.14:11. A copy of the notice and report shall be provided to the Bureau of Insurance. Such proceeding shall be separate from the regulatory office of the Department that conducted the examination, review, or investigation and shall be closed and confidential. The records of the proceedings shall be privileged and confidential and shall not be subject to subpoena.

The adjudication officer shall provide a recommendation to the Commissioner, including findings of fact, conclusions, and appropriate disciplinary action or sanction. The Commissioner will promptly notify the Bureau of Insurance if the recommended disciplinary action or sanction proposes probation, suspension, nonrenewal, or revocation of a certificate of quality assurance, or the temporary restriction or prohibition of new enrollments in a managed care health insurance plan. The Commissioner may affirm, modify, or reverse such recommendation and shall issue a final decision.

The Commissioner's decision may be appealed directly to a circuit court under Article 4 (§ 9-6.14:15 et seq.) of the Administrative Process Act. The only parties to the case shall be the managed care health insurance plan licensee and the Department. The Commissioner shall promptly notify the Bureau of Insurance of the commencement and final determination of an appeals proceeding.

C. If a certificate of quality assurance has been revoked or suspended or a certificate holder has been placed on probation, a new certificate may be issued or the suspension may be terminated or the probation removed by the Commissioner after satisfactory evidence is submitted to him that the conditions upon which revocation, suspension, or probation was based have been corrected and after proper examination has been made and compliance with all provisions of this article and the regulations of the Board has been shown.

§ 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 to which complaints shall be directed and shall also specify any required limits imposed by or on behalf of the managed care health insurance plan.

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 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 Personnel and Training 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.

Article 1.2.

Utilization Review Standards and Appeals.

§ 32.1-137.7. Definitions.

As used in this article:

"Adverse decision" means a utilization review determination by the utilization review entity that 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.

"Covered person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

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

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

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

"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) review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services, (ii) any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital, or (iii) any determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through 38.2-132 and 38.2-134.

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

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

§ 32.1-137.8. Application to and compliance by utilization review entities.

A. No utilization review entity shall perform utilization review with regard to hospital, medical or other health care resources rendered or proposed to be rendered to a covered person except in accordance with the requirements and standards set forth in this article.

B. This article shall not apply to utilization review performed under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act or under contract with a plan otherwise exempt from operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974.

C. This article shall not apply to private review agents subject to Chapter 53 (38.2-5300 et seq.) of Title 38.2 of the Code of Virginia.

D. This article shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services.

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

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

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

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

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

§ 32.1-137.10. Utilization review plan required.

A. Each utilization review entity subject to this article shall adopt a utilization review plan that contains procedures for complying with the requirements and standards of § 32.1-137.9 and other applicable provisions of this article. Such plan shall contain at a minimum the following:

1. Specific procedures to be used in review determinations;

2. A provision for advance notice to covered persons of any requirements for certification of the health care setting or pre-approval of the necessity of health care service or any other prerequisites to approval of payment;

3. A provision for advance notice to covered persons that compliance with the review process is not a guarantee of benefits or payment under the health benefit plan;

4. A provision for a process for reconsideration of adverse decisions in accordance with § 32.1-137.14 and an appeals process in accordance with § 32.1-137.15; and

5. Policies and procedures designed to ensure confidentiality of patient-specific medical records and information in accordance with subsection C of § 32.1-137.12.

B. Each utilization review entity subject to this chapter shall make available to providers and covered persons, upon written request, a copy of those portions of its utilization review plan relevant to the specific request.

C. The Commissioner shall have the right to determine that an entity has complied with the requirement that the entity adopt a utilization review plan in accordance with subsection A.

§ 32.1-137.11. Accessibility of utilization review entity.

A utilization review entity shall provide accessibility for covered persons and providers by free telephone at least forty hours per week during normal business hours. Entities located outside of the eastern time zone shall provide covered persons advance written notification of the eastern time zone hours during which those entities are accessible; however, such hours shall be no less than forty hours per week during normal business hours. The entity shall install and maintain an adequate telephone system that accepts and records messages or accepts and provides recorded business hour information for incoming calls outside of normal business hours.

§ 32.1-137.12. Emergencies; extensions; access to and confidentiality of patient-specific medical records and information.

A. For emergency health care, authorization may be requested by the covered person, his representative, or his provider either within forty-eight hours of or by the end of the first business day following the rendering of the emergency health care, whichever is later.

B. An entity shall promptly review a request from the covered person, his representative, or his provider for an extension of the original approved duration of health care or hospitalization. If the entity fails to confirm that termination of health care or hospitalization will occur on the original date authorized, the entity shall review retrospectively whether the extension of health care or hospitalization was medically appropriate.

C. Each entity shall have reasonable access to patient-specific medical records and information.

§ 32.1-137.13. Adverse decision.

A. The treating provider shall be notified in writing of any adverse decision within two working days

of the decision. Any such notification shall include instructions for the provider on behalf of the covered person to seek a reconsideration of the adverse decision, including a contact name, address, and telephone number.

B. No entity shall render an adverse decision unless it has made a good faith attempt to obtain information from the provider. At any time before the entity renders its 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.

§ 32.1-137.14. Reconsideration of adverse decision.

A. Any reconsideration of an adverse decision shall be requested by the provider on behalf of the covered person. A decision on reconsideration shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel.

The treating provider on behalf of the covered person shall be notified of the determination of the reconsideration of the adverse decision, in accordance with § 32.1-137.9, including the criteria used and the clinical reason for the adverse decision, the alternate length of treatment of the alternate treatment setting or settings, if any, that the entity deems to be appropriate, and the opportunity for an appeal pursuant to § 32.1-137.15.

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

§ 32.1-137.15. Final adverse decision; appeal.

A. Each entity shall establish an appeals process, including a process for expedited appeals, to consider any final adverse decision that is appealed by a covered person, his representative, or his provider. Except as provided in subsection E, notification of the results of the appeal process shall be provided to the appellant no later than sixty 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.

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

The utilization review entity shall decide the expedited appeal no later than one business day after receipt by the entity of all necessary information.

An expedited appeal may be requested only when the regular reconsideration and appeals process will delay the rendering of health care in a manner that would be detrimental to the health of the patient. 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 Chapter 53 (§ 38.2-5300 et seq.) of Title 38.2, 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 this chapter and this article shall maintain or cause to be maintained, in writing and at a location accessible to employees of the Department, records of review procedures; the health care qualifications of the entity's staff; the criteria used by the entity to make its decisions; records of complaints received, including the manner in which the complaints were resolved; the number and type of adverse decisions, and reconsiderations; the number and outcome of final adverse 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.) of this chapter shall be maintained from the date of the entity's last examination and for no less than five years.

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

§ 32.1-137.17. Limitation on Commissioner's jurisdiction.

The Commissioner shall have the right to determine compliance with this article; however, the Commissioner shall have no jurisdiction to adjudicate individual controversies arising out of or incidental to this article.

§ 38.2-511. Failure to maintain record of complaints.

No person other than agents or brokers, shall fail to maintain a complete record of all the complaints that it has received since the date of its last examination under § 38.2-1317 ~~or during the last three years, whichever is the more recent time period~~, *provided that the records of complaints of a health carrier subject to Chapter 58 (§ 38.2-5800 et seq.) of this title shall be retained for no less than five years*. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint.

As used in this section, "complaint" shall mean any written communication from a policyholder, subscriber or claimant primarily expressing a grievance.

§ 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, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 ~~and~~, Chapter 53 (§ 38.2-5300 et seq.), *and Chapter 58 (§ 38.2-5800 et seq.)* of this title shall apply to the operation of a plan.

§ 38.2-4301. Establishment of health maintenance organizations.

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

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

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

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

3. A list of the names, addresses, and official positions of each member of the governing body, and a full disclosure in the application of (i) any financial interest between any officer or member of the governing body or any provider, organization or corporation owned or controlled by such person and the health maintenance organization, and (ii) the extent and nature of the financial arrangements between such persons and the health maintenance organization;

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

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

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

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

8. A complete description of the health maintenance organization and its method of operation, including (i) the method of marketing the plan, (ii) a financial plan that includes a three-year projection of the anticipated initial operating results, (iii) a statement regarding the sources of working capital as well as any other sources of funding, and (iv) a description of any insurance, reinsurance or alternative coverage arrangements proposed;

~~9. A description of the geographic areas to be served;~~

~~10. A description of the complaint system required in § 38.2-4308;~~

~~11. A description of the procedures and programs established by the health maintenance organization to (i) assure both availability and accessibility of adequate personnel and facilities, and (ii) assess the quality of health care services provided;~~

~~12.~~ *9.* A description of the mechanism by which enrollees will be given an opportunity to participate in matters of policy and operation as provided in subsection B of § 38.2-4304; and

~~13.~~ *10.* Any other information the Commission may require to make the determinations required pursuant to § 38.2-4302.

~~C. Unless otherwise provided for in this chapter, a health maintenance organization shall file notice with the Commission describing any modification of the operation set out in the information required by subsection B of this section. The notice shall be filed with the Commission within thirty days after the effective date of the modification.~~

§ 38.2-4302. Issuance of license; fee.

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

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

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

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

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

b. The adequacy of working capital;

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

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

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

duly performed;

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

5. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-4301 *or Chapter 58 (§ 38.2-5800 et seq.) of this title* or by independent investigation.

§ 38.2-4307. Annual statement.

A. Each health maintenance organization shall file a statement with the Commission annually by March 1. The statement shall be verified by at least two principal officers and shall cover the preceding calendar year. Each health maintenance organization shall also send a copy of the statement to the State Health Commissioner.

B. The statement shall be on forms prescribed by the Commission and shall include:

1. A financial statement of the organization, including its balance sheet and income statement for the preceding year;

2. Any material changes in the information submitted pursuant to subsection B of § 38.2-4301;

3. The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year; and

4. Any other information relating to the ~~performance and utilization of the health maintenance organization required by the Commission after consultation with the State Health Commissioner to carry out the Commission's duties under this chapter~~ *operations of the health maintenance organization required by the Commission pursuant to this chapter or Chapter 58 (§ 38.2-5800 et seq.) of this title.*

C. If the health maintenance organization is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the Commission by June 30.

D. The Commission may extend the time prescribed for filing annual statements or other reports or exhibits of any health maintenance organization for good cause shown. However, the Commission shall not extend the time for filing annual statements beyond sixty days after the time prescribed by subsection A of this section. Any health maintenance organization which fails to file its annual statement within the time prescribed by this section shall be subject to a fine as specified in § 38.2-218.

§ 38.2-4312. Prohibited practices.

A. No health maintenance organization or its representative may cause or knowingly permit the use of (i) advertising that is untrue or misleading, (ii) solicitation that is untrue or misleading, or (iii) any form of evidence of coverage that is deceptive. For the purposes of this chapter:

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee or person considering enrollment in a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if the statement or item of information may be understood by a reasonable person who has no special knowledge of health care coverage as indicating (i) a benefit or advantage if that benefit or advantage does not in fact exist or (ii) the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee or person considering enrollment in a health care plan if the absence of that exclusion, limitation, or disadvantage does not in fact exist; consideration shall be given to the total context in which the statement is made or the item of information is communicated; and

3. An evidence of coverage shall be deemed to be deceptive if it causes a reasonable person who has no special knowledge of health care plans to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage; consideration shall be given to the evidence of coverage taken as a whole and to the typography, format, and language.

B. The provisions of Chapter 5 (§ 38.2-500 et seq.) of this title shall apply to health maintenance organizations, health care plans, and evidences of coverage except to the extent that the Commission determines that the nature of health maintenance organizations, health care plans, and evidences of coverage render any of the provisions clearly inappropriate.

~~C. No health maintenance organization may cancel or refuse to renew the coverage of an enrollee on the basis of the status of the enrollee's health.~~

~~D.~~ *C.* No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature (i) any of the words "insurance," "casualty," "surety," "mutual," or (ii) any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or fidelity and surety insurer doing business in this Commonwealth.

~~E.~~ *D.* No health maintenance organization shall discriminate on the basis of race, creed, color, sex or religion in the selection of health care providers for participation in the organization.

~~F.~~ *E.* No health maintenance organization shall unreasonably discriminate against physicians as a

class or any class of providers listed in § 38.2-4221 or pharmacists when contracting for specialty or referral practitioners or providers, provided the plan covers services which the members of such classes are licensed to render. Nothing contained in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the numbers of providers necessary to render the services offered by the health maintenance organization.

~~G. The following provisions shall apply whenever a health maintenance organization provides an enrollee who is also a resident of a continuing care facility with coverage for Medicare benefits and the enrollee's primary care physician determines that it is medically necessary for the enrollee to be referred to a skilled nursing unit:~~

~~1. The health maintenance organization shall not require that the enrollee relocate to a skilled nursing unit outside the continuing care facility if (i) the continuing care facility's skilled nursing unit is certified as a Medicare skilled nursing facility and (ii) the continuing care facility agrees, as to such skilled nursing unit, to become a contracting provider in accordance with the health maintenance organization's standard terms and conditions for its participating providers.~~

~~2. A continuing care facility that satisfies clauses (i) and (ii) of subdivision 1, shall not be obligated to accept as a skilled nursing unit patient any one other than a resident of the continuing care facility; and neither the health maintenance organization nor the continuing care facility shall be allowed to include the skilled nursing unit or facilities on the list required by § 38.2-4311 or to advertise in any other way that the facility's skilled nursing unit is a participating provider with respect to coverage offered by the health maintenance organization for Medicare benefits or skilled nursing unit facilities for other than the continuing care facility's residents.~~

~~3. As used in this subsection, "Medicare benefits" means medical and health products, benefits and services offered in accordance with Title XVIII of the United States Social Security Act and "continuing care facility" means a continuing care retirement community regulated pursuant to Chapter 49 (§ 38.2-4900 et seq.) of this title.~~

§ 38.2-4316. Suspension or revocation of license.

A. The Commission may suspend or revoke any license issued to a health maintenance organization under this chapter if it finds that any of the following conditions exist:

1. The health maintenance organization is operating significantly at variance with its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 38.2-4301, unless amendments to those submissions have been filed with and approved by the Commission;

2. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that do not comply with the requirements of § 38.2-4306;

3. The health care plan does not provide or arrange for basic health care services or limited health care services;

~~4. The State Health Commissioner certifies to the Commission that the health maintenance organization is unable to fulfill its obligations to furnish quality health care services as set forth in its health care plan consistent with prevailing medical care standards and practices in the Commonwealth;~~

~~5.~~ *4.* The health maintenance organization is no longer financially responsible and a reasonable expectation exists that it may be unable to meet its obligations to enrollees or prospective enrollees;

~~6.~~ *5.* The health maintenance organization has failed to implement a mechanism providing the enrollees with an opportunity to participate in matters of policy and operation as provided in § 38.2-4304;

~~7. The health maintenance organization has failed to implement the complaint system required by § 38.2-4308 to resolve valid complaints reasonably;~~

~~8.~~ *6.* The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

~~9.~~ *7.* The continued operation of the health maintenance organization would be hazardous to its enrollees; or

~~10.~~ *8.* The health maintenance organization has otherwise failed to substantially comply with the provisions of this chapter.

B. When the license of a health maintenance organization is suspended, the health maintenance organization shall not enroll any additional enrollees during the period of the suspension except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation.

C. The Commission shall not revoke or suspend the license of a health maintenance organization upon any of the grounds set out in subsection A of this section until it has given the organization ten days' notice of the proposed revocation or suspension and the grounds for it, and has given the organization an opportunity to introduce evidence and be heard. Any hearing authorized by this section may be informal. The required notice may be waived by the Commission and the health maintenance

organization.

D. When the license of a health maintenance organization is revoked, the organization shall proceed to wind up its affairs immediately following the effective date of the order of revocation. The health maintenance organization shall conduct no further business except as may be essential to the orderly conclusion of its affairs. It shall engage in no further advertising or solicitation. The Commission may, by written order, permit further operation of the organization that it finds to be in the best interests of enrollees for the purpose of giving them the greatest practical opportunity to obtain continuing health care coverage.

§ 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, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§ 38.2-5300 et seq.) and Chapter ~~54~~ ~~(§ 38.2-5400 et seq.)~~ *58 (§ 38.2-5800 et seq.)* of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

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

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

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

§ 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, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.10, 38.2-3415, 38.2-3541, and 38.2-3600 through 38.2-3603*, and Chapter 58 (§ 38.2-5800 et seq.) of this title* shall apply to the operation of a plan.

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

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

CHAPTER 58.

MANAGED CARE HEALTH INSURANCE PLANS.

§ 38.2-5800. Definitions.

As used in this chapter:

"Accident and sickness insurance company" means a person subject to licensing in accordance with provisions in Chapter 10 (§ 38.2-1000 et seq.) or Chapter 41 (§ 38.2-4100 et seq.) of this title seeking or having authorization (i) to issue accident and sickness insurance as defined in § 38.2-109, (ii) to issue the benefit certificates or policies of accident and sickness insurance described in § 38.2-3801, or (iii) to provide hospital, medical and nursing benefits pursuant to §§ 38.2-4116 and 38.2-4123.

"Affiliated provider" means any provider that is employed by or has entered into a contractual agreement either directly or indirectly with a health carrier to provide health care services to members of a managed care health insurance plan for which the health carrier is responsible under this chapter.

"Basic health care services" means emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiological services, and preventive health services. "Basic health care services" shall also mean limited treatment of mental illness and substance abuse as set forth in § 38.2-3412.1 or in the case of a health maintenance organization shall be in accordance with

such minimum standards set by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) of this title.

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

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

"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.

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

"Health carrier" means an entity subject to Title 38.2 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 entity providing a plan of health insurance, health benefits or health services, an accident and sickness insurance company, a health maintenance organization, or a nonstock corporation offering or administering a health services plan, a hospital services plan, or a medical or surgical services plan, or operating a plan subject to regulation under Chapter 45 (§ 38.2-4500 et seq.) of this title.

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

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

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

"Medical necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"Network" means the set of providers directly or indirectly managed, owned, under contract with or employed directly or indirectly by a health carrier for the purpose of delivering health care services to the covered persons of a MCHIP.

"Provider" or "health care provider" means any hospital, physician, or other person authorized by statute, licensed or certified to furnish health care services.

"Service area" means a clearly defined geographic area in which a health carrier has directly or indirectly arranged for the provision of health care services to be generally available and readily accessible to covered persons of a MCHIP.

§ 38.2-5801. General provisions.

A. No person shall operate a MCHIP in this Commonwealth unless the health carrier who directly or indirectly manages, owns, contracts with, or employs the providers for the plan is licensed in accordance with provisions in this title as an insurance company, a health maintenance organization, or a nonstock corporation organized in accordance with provisions in Chapter 42 (§ 38.2-4200 et seq.) or Chapter 45 (§ 38.2-4500 et seq.) of this title. Such health carrier shall be deemed responsible for the MCHIP and its compliance with this chapter and the provisions of Title 32.1 concerning quality

assurance of MCHIPs. A health carrier may be responsible for more than one MCHIP; however, no MCHIP shall have more than one responsible health carrier.

B. Except as provided in subsection C, no person shall operate a MCHIP in this Commonwealth unless the health carrier responsible for the MCHIP holds an active or temporarily suspended certificate of quality assurance issued by the Department of Health.

C. 1. A health maintenance organization applying for licensure under this title on or after July 1, 1998, or whose application for such licensure is pending before the Commission on July 1, 1998, shall request its initial certificate of quality assurance prior to licensing and a copy of its request shall be included with and made a part of the licensing application and material filed with the Commission pursuant to § 38.2-4301 and subsection B of § 38.2-5802. Until July 1, 2000, (i) issuance of a license under § 38.2-4302 shall be contingent upon receipt of notice from the State Health Commissioner that the health maintenance organization's description of its complaint system has been reviewed and approved by the State Health Commissioner and (ii) upon issuance of the license such health maintenance organization shall be deemed in compliance with subsection B provided no certificate of quality assurance has been issued to the health maintenance organization which has been revoked or not renewed by the State Health Commissioner. Effective July 1, 2000, issuance of a license under § 38.2-4302 shall be contingent upon the Department of Health's issuance of a certificate of quality assurance.

2. Until July 1, 2000, a health maintenance organization licensed under this title on and before July 1, 1998, shall be deemed in compliance with the provisions of this section if (i) a request for initial certification has been filed with the Department of Health on or before December 1, 1998, and is pending before the State Health Commissioner and (ii) no certificate has been issued to the health maintenance organization which has been revoked or not renewed by the State Health Commissioner.

3. A health carrier, other than a health maintenance organization, responsible for a MCHIP pursuant to this chapter, shall request its initial certificate of quality assurance from the Department of Health on or before December 1, 1998, or becoming responsible for a MCHIP under this title. Until July 1, 2000, such health carrier shall be deemed in compliance with the provisions of this section if (i) a request for initial certification is pending before the Department of Health and (ii) no certificate has been issued to the health carrier which has been revoked or not renewed by the State Health Commissioner.

D. The provisions of this chapter shall apply to all health carriers and all MCHIPs operating in this Commonwealth unless an exemption is recognized in accordance with § 38.2-3420; and, except as otherwise provided in this chapter, the provisions of this chapter shall be supplemental and in addition to those otherwise applicable under this title or Title 32.1.

§ 38.2-5802. Establishment of a MCHIP.

A. A health carrier, when applying for initial licensing under this title and with each request for renewal that is to be effective on or after July 1, 1999, shall describe and categorize generally its transactions and operations in this Commonwealth that influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services through its MCHIPs. Descriptions and categorization shall identify generally the arrangements that the health carrier has with providers with respect to the delivery of health care services. Descriptions of incentive arrangements shall include compensation methodology and incentives. The descriptions of incentive arrangements shall not include amounts of compensation and values of incentives. Renewal filings shall clearly identify new matter and material changes of information disclosed in the preceding filing.

B. A health carrier applying to the Department of Health for initial certification of quality assurance shall simultaneously file a copy of its request for certification with the Commission and shall include the list of providers required by § 38.2-5805. Such filings shall be assessed by the Department of Health.

C. In addition to items specified in subsection B, the initial filing under this chapter by a health carrier subject to subsection B of § 38.2-5801 shall include any forms of contracts, including any amendments thereto, made with health care providers enabling the health carrier to provide health care services through its MCHIPs to covered persons. Individual provider contracts and contracts with persons outside this Commonwealth shall not be filed with the Commission unless requested by the Commission or necessary to explain or fully disclose pursuant to subsection D operational changes that are materially at variance with the information currently on file with the Commission. The health carrier shall maintain a complete file of all contracts made with health care providers which shall be subject to examination by the Commission. The contracts shall be retained in the file for period of at least five years after their expiration. Notwithstanding the provisions of Chapter 21 (§ 2.1-340 et seq.) of Title 2.1, such contracts shall be confidential and shall not be subject to discovery upon subpoena.

D. No MCHIP shall be operated in a manner that is materially at variance with the information submitted pursuant to this section. Any change in such information which would result in operational

changes that are materially at variance with the information currently on file with the Commission shall be subject to the Commission's prior approval. If the Commission fails to act on a notice of material change within thirty days of its filing, the proposed changes shall be deemed approved. A material change in the MCHIP's health care delivery system shall be deemed to result in operational changes that are materially at variance with the information on file with the Commission. The Commission may determine that other changes are material and may require disclosure to secure full and accurate knowledge of the affairs and condition of the health carrier.

E. A health carrier shall give notice to the State Health Commissioner of the filings it makes with the Commission pursuant to this section.

§ 38.2-5803. Disclosures and representations to covered persons.

A. The following shall be provided to the MCHIP's covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and shall be made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.

2. A description of the service area or areas within which the MCHIP shall provide health care services.

3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.

4. Notice that the MCHIP is subject to regulation in this Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

B. The following shall apply to MCHIPs that require a covered person to select a primary care physician with respect to the offer of basic health care services by the MCHIP:

1. At the time of enrollment each covered person shall have the right to select a primary care physician from among the health carrier's affiliated primary care physicians for the MCHIP, subject to availability.

2. Any covered person who is dissatisfied with his primary care physician shall have the right to select another primary care physician from among the affiliated primary care physicians, subject to availability. The health carrier may impose a reasonable waiting period for this transfer.

§ 38.2-5804. Complaint system.

A. A health carrier subject to subsection B of § 38.2-5801 shall establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints in accordance with requirements in or established pursuant to provisions in this title and Title 32.1 and shall include the following:

1. A record of the complaints shall be maintained for no less than five years.

2. Such health carrier 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 to which complaints shall be directed and shall also specify any required limits imposed by or on behalf of the MCHIP.

B. The Commission, in cooperation with the State Health Commissioner, 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 chapter shall be assessed by the State Health Commissioner pursuant to provisions in Title 32.1 and the regulations promulgated thereunder. 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 this title, shall be assessed by the Commission.

C. The health carrier for each MCHIP shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission and the Board of Health. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the grievance or 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 MCHIP's affiliated providers.

D. The provisions of Chapter 5 (§ 38.2-500 et seq.) of this title shall apply to the health carrier, its MCHIPs, and evidence of coverage and representations thereto, except to the extent that the Commission determines that the nature of the health carrier, its MCHIP, and evidences of coverage and representations thereto render any of the provisions clearly inappropriate.

§ 38.2-5805. Provider contracts.

A. Each health carrier subject to subsection B of § 38.2-5801 shall file with the Commission a list of the current providers who have executed a contract directly with the health carrier or indirectly through

an intermediary organization for the purpose of providing health care services pursuant to a MCHIP or for the benefit of a covered person of a MCHIP. The list shall include the names and localities of the providers. The list shall be updated by the health carrier at least annually and more frequently as required by the Commission in accordance with provisions in this title or by the State Health Commissioner in accordance with provisions in Title 32.1.

B. Every contract with a provider of health care services enabling a MCHIP to provide health care services shall be in writing.

C. When the health carrier is a health maintenance organization, the contracts with providers enabling the MCHIP to provide health care services to the covered persons shall contain a "hold harmless" clause setting forth that, in the event such health carrier fails to pay for health care services as set forth in the contract, the covered persons shall not be liable to the provider for any sums owed by the health carrier. The following requirements shall apply to such contracts:

1. Such contracts shall require that if the provider terminates the agreement, the provider shall give the health carrier at least sixty days' advance notice of termination.

2. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier.

3. If there is an intermediary organization enabling a health carrier subject to subsection B of § 38.2-5801 to provide health care services by means of the intermediary organization's own contracts with health care providers, the contracts between the intermediary organization and its providers shall be in writing.

4. The contracts shall set forth that, in the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the health carrier.

5. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization.

6. An agreement to provide health care services between an intermediary organization and a health carrier subject to subsection B of § 38.2-5801 shall require that if the intermediary organization terminates the agreement, the intermediary organization shall give the health carrier at least sixty days' advance notice of termination.

7. An agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination.

8. Each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract.

9. The "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. The health carrier may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to the covered persons.

Hold Harmless Clause

[Provider] hereby agrees that in no event, including, but not limited to nonpayment by the MCHIP or its health carrier, the insolvency of the [health carrier], or breach of this agreement, shall [Provider] bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against subscribers or persons other than the health carrier for services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the subscriber agreement for the MCHIP.

[Provider] further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the plan's subscribers and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between [Provider] and the subscriber or persons acting on the subscriber's behalf.

10. If there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause set forth in subdivision 5 shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization.

D. The Commission may specify for each type of health carrier other than a health maintenance organization the circumstances, if any, under which a health carrier for a MCHIP shall contract with a

provider with the "hold harmless" clause described in subsection C. The Commission may specify also the extent to which certain accounting treatment, reserves, net worth or surplus shall be required for liabilities arising from provider contracts without the "hold harmless" clause.

§ 38.2-5806. Prohibited practices.

A. No MCHIP licensee may cancel or refuse to renew the coverage of a covered person for basic health care services on the basis of the status of the covered person's health.

B. The following provisions shall apply whenever a MCHIP provides a covered person who is also a resident of a continuing care facility with coverage for Medicare benefits and the covered person's primary care physician determines that it is medically necessary for the covered person to be referred to a skilled nursing unit:

1. The health carrier shall not require that the covered person relocate to a skilled nursing unit outside the continuing care facility if (i) the continuing care facility's skilled nursing unit is certified as a Medicare skilled nursing facility and (ii) the continuing care facility agrees, as to such skilled nursing unit, to become a contracting provider in accordance with the health carrier's standard terms and conditions for its participating providers.

2. A continuing care facility that satisfies clauses (i) and (ii) of subdivision 1 shall not be obligated to accept as a skilled nursing unit patient any one other than a resident of the continuing care facility; and neither the health carrier nor the continuing care facility shall be allowed to include the skilled nursing unit or facilities on the list required by § 38.2-5802 or to advertise in any other way that the facility's skilled nursing unit is a participating provider with respect to coverage offered by the MCHIP for Medicare benefits or skilled nursing unit facilities for other than the continuing care facility's residents.

As used in this subsection, "Medicare benefits" means medical and health products, benefits and services offered in accordance with Title XVIII of the United States Social Security Act (42 U.S.C. § 1395 et seq.) and "continuing care facility" means a continuing care retirement community regulated pursuant to Chapter 49 (§ 38.2-4900 et seq.) of this title.

C. The following shall apply in accordance with provisions in Title 32.1 or regulations promulgated thereunder:

1. Where complaints of a covered person may be resolved through a specified arbitration agreement, the covered person shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered.

2. No contract or evidence of coverage that entitles covered persons to resolve complaints through an arbitration agreement shall limit or prohibit such arbitration for any claims asserted having a monetary value of $250 or more.

3. If the covered person agrees to binding arbitration, his written acceptance of the arbitration agreement shall not be executed prior to the time the complaint is registered nor subsequent to the time an initial resolution is made, and the agreement shall be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration.

§ 38.2-5807. Access to care.

Access to care shall be assessed by the Department of Health in accordance with provisions in Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 of Title 32.1 concerning quality assurance.

§ 38.2-5808. Examinations.

A. In lieu of or in addition to making its own examination of a MCHIP and its health carrier, the Commission may accept the report of an examination of the health carrier or other person responsible for the MCHIP under the laws of another state certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

B. The Commission shall coordinate examinations of a MCHIP and its health carrier with the State Health Commissioner's examination or review of the health carrier to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

C. The Commission shall accept a current certificate of quality assurance issued by the Department of Health as evidence of compliance by the certificate holder with any provision in this chapter authorizing or requiring assessment by the Department of Health, by the State Health Commissioner, or pursuant to regulations promulgated by the State Health Commissioner.

§ 38.2-5809. Suspension or revocation of license.

The Commission may suspend or revoke any license issued to a health carrier if it finds that any of the following conditions exist:

1. The State Health Commissioner certifies to the Commission pursuant to § 32.1-137.5 that the health carrier or its MCHIP is unable to fulfill its obligations to furnish quality health care services as set forth in Article 1.1 of Chapter 5 (§ 32.1-137.1 et seq.) of Title 32.1. The suspension of a certificate of quality assurance shall not be deemed such a certification by the State Health Commissioner.

2. The State Health Commissioner notifies the Commission that the health carrier has failed to

implement the complaint system required by Title 32.1 and § 38.2-5804 to resolve valid complaints reasonably.

3. The Commission determines that a certificate of quality assurance issued to the health carrier has been revoked by the State Health Commissioner, or a request for renewal of such certificate has been denied or disapproved by the State Health Commissioner.

§ 38.2-5810. Statutory construction and relationship to other laws.

A. Neither the health carrier nor the MCHIP shall be deemed to be engaged in the practice of medicine solely by virtue of its compliance with this chapter. All health care providers associated with a MCHIP shall be subject to all provisions of law.

B. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health carrier providing a MCHIP subject to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the MCHIP's service area.

§ 38.2-5811. Controversies involving contracts.

The Commission shall have no jurisdiction to adjudicate controversies between a MCHIP and its covered persons, and a breach of contract shall not be deemed a violation of this chapter.

2. That §§ 38.2-4308 and 38.2-4311 and Chapter 54 (§ 38.2-5400 through 38.2-5409) of Title 38.2 of the Code of Virginia are repealed.

3. That the Commissioner of the Department of Health shall report annually to the Joint Commission on Health Care the status of this legislation, including, but not limited to (i) the criteria developed by which managed health care insurance plans are reviewed and evaluated; (ii) the number of quality assurance certificates issued by the Department; (iii) the number of quality assurance certificates denied by the Department and the reasons for the denial; (iv) the status of the periodic reviews for complaint investigations and compliance with the quality of care certificate standards established by this bill; and (v) the number and amount of civil penalties which were imposed during that year for noncompliance.